		١.		State of Ma							•	_	ible.	10001
			1 - For Stete Registrar					te of D			R	eg. No.	Ub	10001
	Physic /Medi		1. Decedent's Name (First, Middle, La Marie Elizabeth I	aib						m	ate of Dear	12, Z	2006	3. Time of Death
1	Examir	ner	4a. Facility Name (If not institution, giv		Tal	/	4b. City	A/TI	Location of Dea	ith	′	4c. Count	y of Death a	1
	Funeral Director		5. Social Security Number 6. S 212-20-4605	1000	e (In yrs.	last birthday) 9 Yrs.	tf Und Months	er 1 Year Days	If Under 24 Hr Hours Mir	s. 8. D	ate of Birth Month, Day	Year) 1926	9. Birth Cou Mar	nplace (State or Foreign Intry) Yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					-		10d. Inside City Limits
	B Mary	ctor	Maryland n/a		Ba	ltimor	re							1 ☐ Yes 2 🔀 No
	with the a or 26	Funeral Director	10e. Street and Number 3300 Benson Avent	ne Ant. 22	2			ip Code 21227			1	Og. Citizen of Unite		-
	death sme 23	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.			panic Origin? (, Mexican, Pue	Specify Specify	res or No-	14. Ra		ican Indian,
Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Item 27 is marked other than "nature!", or Items 23a or 28a-1 show other treumatic event, the Medical Examples must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates:			1 Yes		Specify:	nto nicar	r, 610. /	Speci		nite
15-0	n 72 h "natu edica	olete	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give	dent's Us kind of w	ual Occupat rork done di use retired)	tion uring most of w	orking		16b. Kind of E	3usiness/l	ndustry
212	d withi	Completed	Elementary/Secondary (0-12)	O Cotlege (1-4or !	5+)	house						hom	ie	
pu	be file ntal Hy od oth	Be	17. Father's Name (First, Middle, Last James Capperella)					18. Mother's Na Mary M			Maiden Suma	me)	
ıryla	should nd Mei marke	10	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Addre	ss (Street a	nd Number or F			r, City or Towr	n, State, Z	ip Code)
	ss 1 and 2. of Health at litem 27 is rother trace		Catherine Poetsch	ıan – daugl					ad, Pas	ader				
Baltimore,	Pages 1 nent of He int: If Iter iry or oth		20a. Method of Disposition 1 △Buriat 2 □ Cremation 3 □	Removal from State	0	Place of Dispo cometery, crei 11y Hi	matory or	other place		Date 1.8		20c. Location		Town, State
Itim	2555		4 □Donation 5 □Other (Special 21. Signature of Funeral Service Lice		пО	-			of Facility H					•
Ba	Departiment Departiment Departiment Department Departme		> Unn K	owe										land 21229
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each li					, such as cardi		piratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		1	Due to (or as	a conseq	uence of):								
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):								
	e be executed rsicien and e burial-Iransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	a conseq	uence of):								
760,	e be e.	<u>60</u>		d										
687	ing phy	Medi	IF FEMALE:				_							
P.O. Box	Physicien: The law requires that the death certificate trist certificate hes been signed by the attending physial director, page 2 should be detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. tf yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	Ideath 3	⊒Ectopic ⊒ Other (pregnancy specify)				1	ate of deli Ionth	very Day Year
	quires that the signed by	by	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	inderlying	cause give	n in Part I.			bacco use cor es 2 □ No		the cause of death?
Records,	The law requirate hes been single 2 should	Completed			trainin drado-sara-tra						24a. Was a autops perform	an 24b sy med? 2 No	. Were au prior to death?	topsy findings available completion of cause of
ے / Vital	ysicien: The lis certificete ho	Bec	25. Was case referred to medical examiner?						26. Place of D					
0 5	Physi r this o	. To	1 ☐ Yes 2 🗹 No 27. Manper of Death	Hospital: 1 ☐ Inpatie		ER/Outpatier			4 🗀 Nursing	-		ence 6 🗆 O		cify)
F io	Attending For death. • ctor: After by the funer	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	1	y Yeer)	Injury	М	28c. Injury Work′ 1 □ Y	? es 2 □ No					
Division	To the Hoepital or Attendin within 24 hours after death. To the Funerel Director: Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of tnj building, et	ury - At ho c. (Specif	ome, farm, str	reet, facto	ory, office	····		ocation (S. City or Town		nber or Ru	ral Route Number,
	e Hoepi 124 hour Funer letely filt	Medical	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the best niner: On the basis of and manner sta	fexamina	wledge, deat tion and/or in	h occurre vestigation	d at the time on, in my opi	e, date and placinion, death occ	ce, and o	ue to the c	ause(s) and n late and place	nanner as , and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	L~ MD			1 -	9c. License				9d. Date sign		
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1	+			+ Agres Mi	sp.ta		Print) Cath	onAve	we Bi	iltu	nose, l	naryla	al z	1229
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 20	32 Registr	ar a argna	y An	orth	7						

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Garry Marshall Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Deatl Physician/ Month Year 1436 hrs May 15, 2006 **Medical Examiner** ARNE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore City** Johns Hopkins Hospital 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY) . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Country)MARYLAND Director 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State Ob. County any 1 X Yes 2 No or 28a-f show 1/1RYLAND notified at once. with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 00. items 23a 14 Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S 11. Marital Status White, etc. Armed Forces? hours after death 1 X Never Married 2 Married Yes 0. If Yes, Give Year 1 Yes 2 X No specify: Specify: 4 Divorced it. Pages 1 and 2 should be filed within 72 hours after trment of Health and Mental Hygiene retant: If item 27 is marked other than "natural", is yor other traumatic event, the Medical Examiner; yor other traumatic event, Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 ++GRADE YEMOR 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAINES æ (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) NO MD. 20b Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line. Death /Medical Alcohol intoxication complicated by maitional asphyxia Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical item#23a,27,28a-f,perME,g855,5/22/06 TT X UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves. outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ned by the atte Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? DOA Nursing Home 5 Residence 6 Other Inpatient 2 PER/Outpatient 3 this 1 🗸 Yes ို No 28d. Describe how injury occurred Asphyxiation caused by body position on park bench 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After 27. Manner of Death 1 Natural 1 Yes 2 X No 5 Pending 24 hours after death. Funeral Director: 5/15/2006 Fnd 2:23 PM while intoxicated the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 114 North Front St. Baltimore MD 3 Suicide (Specify) park Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 1 within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number May 16, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (It m 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registrar's Signature 31. Date filed Month, Day, Year 2006 State Registrar

		-	State of Marylar	•	artment of H rtificate of I		lental H	giene Reg. No.	2006	15503
	9		Registrar 1. Decedent's Name (First, Middle, Last)		01	1	2. Date of D	eath		3. Time of Death
п	Physicia		HELEN		11/04	on	Month	Day	200G	5.15 PM
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	<i>i</i> /	4b. City, Town, or	Location of Death	1 417	4c.	County of Death	
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	Funeral		10M 200E	last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D		Cou	
	Director	-	237-92-1684 55 Usuel Residence of Decedent	113.			Nov 15	, 195	0 Nort	h Carolina
	land ow			ty, Town or L	ocation					10d. Inside City Limits
	Man	to	MD Ba	1timor	e					1K∐Yes 2 No
	th the	Director	10e. Street and Number		10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	ter death with the Marylan Items 23a or 28a-f show Iter must be notified at		2021 Wilhelm Street		21223			[USA	
	r dea	Funeral	11. Marital Status unk 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or N Rican, etc.)	10-	 Race - Ameri Black, White, 	
36	72 hours after death with the Maryland natural; or Items 23a or 28a-f show deat Evar a we must be modified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify:	
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21215-0036	9	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	(Give	kind of work done of DO NOT use retired	during most of worki ()	ing			·
21		E O	Elementary/Secondary (0-12) College (1-4or 5+) none	Unen	nployed			No	one	
pu	be filed vital Hygie od othar l	Be (17. Father's Name (First, Middle, Last) Claude Richard Bowers			18. Mother's Name			Sumame)	
<u>y</u> la	should by	၉				Helen Ir				
=	12 sho h and 7 Is mu traum		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street					Code)
	s 1 and 2 should if Health and Men itam 27 Is marks other traumatic	(S)	Frank Jones/boyfriend 20a. Method of Disposition 20b. 1	Place of Disp	Wilhelm Sosition (Name of		nore, N Date		223 cation - City or T	own, State
	00-		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 🖾 Donation 5 ☐ Other (Specify)	cemetery, cre	matory or other plac	(e)				
Balt	permit. Pag Department Important: I any injury o		21. Signature Ronald S. Wade Directo	or §	2 Name and Address State Anat Baltimore,	omy Board MD 21201	1 655 W	. Bal	Ltimore	Street
			23a. Part1. Inter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not en	ter the mode of dyin	g, such as cardiac o	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	HO	RNIATIO	1				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consecutive for a consecutive	quence of):	, 1/-	1 22	_			200
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	rted	ulu u	cause. Enter Underlying Cause (Disease or injury that initiated events	Amer	SIDUCIA					IENIC
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		0	IS SEMAN S.							
Вох	death certifi e attending p id for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta	al death 3 [☐Ectopic pregnancy			2	3d. Date of deliv	ery Day Year
G	at the dea by the at tached fo	sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of 0	death 5[Other (specify)				WOITE	Day
<u>α</u>	that the		Part II. Other significant conditions contributing to death but not res	sulting in the u	underiving cause give	en in Part I.	23e, Did	tobacco us	se contribute to t	he cause of death?
ds,	uires t signe	d by		g	,		1	Yes 2		
Sor	w requir been si should	lete					24a. Wa	s an	24b. Were auto	psy findings available
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed					auto	opsy formed?	prior to co death? 1 ☐ Yes	mpletion of cause of
		BeC	25. Was case referred to medical examiner?			26. Place of Death			7	2010
of V	d is	10	Hospital	EP/Outpatie		er: 4 🗌 Nursing Ho	me 5 Res	idence 6	Other (Special	ý)
		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	k?	28d. Describe	how injury	occurred	
Sio	ttend death tor: / the f	icat	2 Accident investigation 3 Suicide 6 Could not 28e. Place of Injury - At h	lome form of		Yes 2 □No	29f Location	(Street and	Alumbar or Pur	al Route Number,
Division	tal or Attendii 's after death. al Diractor: A ed in by the fu	Certification:	4 Homicide determined 200. Face of injury. All building, etc. (Speci	ify)	reet, factory, office		City or To	wn, State)	, rvaniba or rigit	arribate realizar,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my kni (2 Medicel Exeminer: On the basis of examinar and manner stated.	owiedge, dea ation and/or in	th occurred at the tin nvestigation, in my o	ne, date and place, a pinion, death occurr	and due to the ed at the time	cause(s) , date and	and manner as s place, and due t	tated. the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier Thurs I Alyelhark	MI	29c. License	S - 000		Ma Date	e signed (Month,	2006
			V. V	,						Comme Co Co
			30. Name and address of person who completed cause of death (Ite	m 23a) (Type	Print)	Ballin	1- VI	Land	land a	1200
	Sta	ato	30. Name and address of person who completed cause of death (Itel Tamer Andelha Don March 1998) 31. Date filed (Month, Day, Year) 32. Registrar's Sign	· Woll	Print) ZE St.	BAHIMO	ce, M	lary,	land to	1287

	1	For State Registrar	11000	S	State o	f Maryl			rtment of l		Mental Hy	/giene	Z 1111	6	550	1
		Decedent's Name (Fi	rst, Middle,	Last)							2. Date of D Month	eath Da	.v Ve	ar 3	. Time of Death	
Physicia		TAME	V	1.	MA	1661	ETT				05	11			4.2001	М
/Medica		a. Facility Name (If not		give stre	et and nur	mber)			4b. City, Town,	or Location of De	ath	40	. County of [Death		
LXamine		Caton Mano	r]	3altmore							
Funeral		5. Social Security Numb		. Sex		7. Age (In	•		If Under 1 Year Months Days		n. (Month, D	ay, Year,)	Birthplac Country	e (State or Forei	
Director		218-18-758	8	1 (X) M	2 □ F	81		Yrs.			Feb 11	, 19	25		unk	<u>.c</u>
P >	-	Usual Residence of Dec 10a. State 10	b. County			100	. City, Tow	n or Loc	ation	-				10d.	Inside City Limit	ts
aryla shov	_		b. County				,								1X Yes 2 □ N	10
88 A	Director	MD				<u>_</u>	Balti	nore	10f. Zip Code			10a, C	itizen of Wha	it Country	?	
with th	吉	10e. Street and Numbe		a .								US		,		
8 23e		911 Leader	n Hall			edent Ever	in II S	13 W	21230		(Specify Yes or N		14. Race	American	Indian,	
er de	Funeral	11. Marital Status 1 Never Married	2□ Marrio		Armed Fo	orces?	unk	If	Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		Black, \	White, etc		
rs aft	by F	3 ☑ Widowed 4 □			If Yes, Gr Year or D	ve		1	☐ Yes 2 X No	Specify:			Specify:	1ack		
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al Hyg	Be	17. Father's Name (First	st, Middle, Li	ast)					unk	18. Mother's N	lame (First, Midd	le, Maide	n Surname)		unk	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland tith and Mental Hygiene. Z7 Is marked other than "neturel", or items 23e or 28e-f show treumetic event, the Medical Examinations to the notified at	2					_				1	Correl Courte Norm	h Cit.	as Tours Of	to Zin Co	oda)	
Aar 2 she and 1s m		19a. Informant's Name									Rural Route Num				000)	
and and lealth m 27		Shani Coll		egal	guar				Calveri	t St. #30	00 Balti	nore 20c. I	MD 2 ocation - Cit	1202 v or Town	, State	
OFF ges 1 t of H to f H or otl		20a. Method of Disposi 1 ☐ Burial 2 ☐ G	remation :	3 □Ren	noval from	State	cemete	ry, crem	atory or other p	lace)				,		
timen treent:		°4 □Donation 5					-	22	Name and Add	ress of Facility						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Importent: If the Maryla marked other than "neturel", or Items 23e or 28e-4 show any injury or other treumetic event, items metrical startings.		21. Signature of Funer Ron	man	// //		· <i>UO</i>		St	ate Anat Itimore	omy Boar	cd 655 W		ltimor	e St	reet	
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K 68 Artificat ling phy e as th	Mec	IF FEMALE:		220	o If you or	utcome of p	regnancy	-	A = 1 - 40°				23d. Date of	of delivery		
Box 687 Box certificate leath certificate attending phy	lan/	23b. Was decedent pr		230	1 Live	birth 2	Fetal deat		Ectopic pregnar Other (specify)			33	Month Month	,	ay Year	
O. E the dear of the a	hysician/Med	1 ☐ Yes 2 ☐ N 9 ☐ Unknown			4∐ Preg 9∏ Unki	nant at time nown	e or deadi	3[Other (specify)							
P.O. that the detection detection	Δ.	Part II. Other significa	nt conditio	ns contr	ributina to	death but no	ot resulting	in the u	nderlying cause	given in Part I.	23e. Di	d tobacco	use contrib	ute to the	cause of death?	
O 8 5 8	1 by	COP		4	4	1 Dz					1[Yes	2 □ No 3	☐ Probab	oly 4 donkno	wn
ecords law require as been sig	ompleted										24a. W	as an	24b. We	re autops	y findings availa detion of cause	ble
Rec Rec s has l	ldm						·				— au	topsy rformed?	dea	ath?		of
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TAME Vital Re systicien: The list certificate had director, page	Be	25. Was case referred examiner?		Но	spital:	74 47 44			at 3 DOA		Death <i>(Check onl</i> ig Home 5 🗆 Re		6 □Other	(Specify)		
of Vita of Vita Physicien: this certific	2	1 ☐ Yes 2 ☑ No 27. Manner of Death)	-	1 _			Time o					jury occurred			
ling After Tune	E I	1 Matural	5 Pending		(Mo	e of Injury onth, Day Ye	ear)	Injury		Vork? □Yes 2□No						
Division of Attending after death. Director: After tin by the fune	flca	0 00.0.00	6 Could r	not be	28e. Plac	ce of Injury	- At home,	farm, str	eet, factory, offic	ce _	28f. Location	(Street	and Number	or Rural I	Route Number,	
Div A affer Dire	Certification:	4 🗌 Homicide	deteilli	iiiou	buil	ding, etc. (S	Specify)				City of	Fown, Sta	10)			
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2	Certifyin	g Physi Examine	er: On the	basis of ex	amination a	ge, deat and/or in	n occurred at the vestigation, in m	time, date and p y opinion, death o	lace, and due to to	ne cause le, date a	(s) and manr and place, an	ner as stat d due to t	ed. ne cause(s)	
the hin 24 the F	Medi	one)		,	and ma	inner stated	1.			ense number		,	Date signed (
To with To cor		29b. Signature and tit	is of certifier		pr-	MA			-		t e		5/11/	6		
		A	we				. //4 =		D 0 0	06263	4		_ / / °			
		30. Name and addres	s of person	who con	npleted ca	use of deat	n (Item 23a) (Type,	Print)	MMINING	EFOR	200	RUAN	BAL	TIMIRE	
Sta	ate.	31. Date filed (Month,	Day, Year)	V	30	Registrar's	Signature	E	(1)	, 93	1 1-121	/		14	9 21227	
Registi		MAY		2006	De	02161	S.	Son	wer.		FERM					

			For Stete Registrar	State of M	aryland / De	epartmen			and M	,	giene	0.06	155	05
. 4	Dhysis	io.	1. Decedent's Name (First, Middle,							2. Date of Dea	ith Day	Year	3. Time of D	
	Physici /Medi	cal	100BEICI /	N ACKEY						5	10	06	2100	М
7	Examir	ner	4a. Facility Name (If not institution,	give street and number)				Location o	-		_	unty of Death		
- 5	- Funda	A	1100		ge (In yrs. last birtho	-		nc.A		8. Date of Birth (Month, Day				Foreian
	Funeral Director		215-52-3975	1 X M 2□ F	56 Yr	Months	Days	Hours	Min.	(Month, Day 04 22	, _{Үөаг)} 2 50	Col	nplace (State or I untry) SC	
	p .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r I costica							104 1-14- 04-	Linia
	Aaryla Febor	ō	MD NA		Balti								10d. tnside City 1 XYes 2	
	the A	Funeral Director	10e. Street and Number			10f. Zip	Code				10g. Citizen	of What Cor	intry?	
	h with	O	2816 Rayner A	ve			2	1216				U.S.	A •	
	deat	ner	11. Maritat Status	12. Was Decedent Armed Forces		13. Was Deced	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Amer Black, White		
36	or it	by Fu	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tyes 2 7		1 ☐ Yes		Specify:		, , , ,			lack	
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or items 23e or 28e-f ehow he Modical Exeminar mat Le notified at	ed b	15. Decedent	Year or Dates:	16a D	ecedent's Usua	al Occupa	ation			16h Kind o	of Business/l		
215	nin 72	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) Coltege (1-4or	(6	give kind of wor fe. DO NOT us	rk done d	turina most	t of workir	ng	rob. rand c	, buomoda,	dudiiy	
	filed with Hygiene other the forth files	Completed	12th grade	na	.,	Pack	er				Arno	old F	actory	
pu	be file d oth	Be	17. Father's Name (First, Middle, L	ast)						(First, Middle,	Maiden Sur	name)		
Maryland	should be find Mental be marked of	10	John Mackey 19a. Informant's Name/Relationsh	in (Tuna Brint)	10b A	lailing Addrson		Fann		(ing Route Numbe	. City or To	Ctata 7	i- Cada)	
S	and 2 s ealth an n 27 is i	i								altimo			1216	
ē,	f Health		Fannie Mackey 20a. Method of Disposition		20b. Place of C		ne of			ate		on - City or 1		
m E	Pages nent of I ont: If its		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		King M	,			5/18	3/06	Randa	illst	own, Mo	đ
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "nature!", or Items 23a or 28a-f ehow any higher treumatic event, the Madical Experiment and the religious 2008.		21. Signature of Funeral Service L	icensee	/	22. Name an March								
w.	80539		Jaken	" lase	h	4300	Wab	ash	<u>Ave</u>	Balt		e, Md	21215	5
		Н	23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cause only one cause on each I	d the death. Do no ine.	enter the mod	le of dying	g, such as	cardiac oi	r respiratory ari	est,		Approximate Interval Betwe Onset and De	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CH										
	Examiner			Due to (or as	a consequence of)									
7	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of)									
P	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с										
60,	sicien and burial-transif	cal Ex	103utting in death) Last	Due to (or as	a consequence of)									
Box 68760,	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transif		η.	d										
X	n certing anding use a	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		-55					23d.	Date of deliv	rery	
	thet fhe death cer ed by the attendir detached for use	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregnant a	2 Fetal death t time of death	3 ☐ Ectopic pro						Month	Day Yea	ar
P.O.	d by the	Phy	9 Unknown						-	V 00. 5:44				
ds,	signed I	by	Part II. Other significant condition	is contributing to death t	out not resulting in the	ie underlying ca	ausa give	in in Parti.			es 2 N		the cause of dea	
Ö	w requir	etec	-VIII GIIV							24a. Was a				
Records,	he lav e has age 2	d mc								autop: perfor	med2/	prior to death?	opsy findings ava	se of
Vital	an: T	a	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes		1 🗆 Yes	2 No	
of V	Physician: this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inpati	ent 2 ER/Outp	atient 3 DO	Othe	200		ne 5 🗆 Resid	17.	Other (Spec	rfy)	
0 0	ing Pl	i.	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tin ay Year) Inju		8c. Injury Work			8d. Describe h	ow injury oc	curred		
Division	Attending in death.	cat	2 Accident investig	ot be One Place of In	jury - At home, farm	M Street feeten		/es 2□N		20f Location /C	troot and Mi	umbos os El	al Route Numbe	
Ďί	for A after Direct	Certification:	4 Homicide determin	building, e	tc. (Specify)	, street, factory	, onice		2	City or Tow	n, State)	MIDEL OF HO	ai Houle Numbe	7,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illed in by the funeral director, page 2.		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge, o	leath occurred	at the tim	e, date and	d place, a	and due to the c	ause(s) and	manner as	stated.	
	in 24 the Fu	edical	(Check only 2 Medical E	xaminer: On the basis of and manner st	ated.	or investigation,	, in my op	oinion, deat	th occurre	ed at the time, d	ate and pla	ce, and due	to the cause(s)	
	To To E	Σ	29b. Signature and title of certifier) 000		290	License	number		. 2	9d. Date sig	gned (Month	Day, Year)	
	2		1. Away	(IVW)	DET	3. Avy	11673	55/54	(>		5 10	1.06		
	5		30. Name and address of person v	no completed cause of a	death (Item 23a) (Ty	pe, Print)	CVI	M	APV	1.4000	MIST	of Ar	FAMES	×
9	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	VYV.	UT	//lw		CONVID	10151	JUNC	10000	
	Registi		MAY 1	7 2006	Elica St	Sasti	2							

•	1	For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No.	006	15506
Physician /Medical Examiner Funeral Director	4	1/8-12-014/	street and number)	CKQ.	4b. City, Town, or KIN CO If Under 1 Year Months Days	Location of Death TO JOGUE If Under 24 Mrs. Hours Min.	2. Date of De Month MAY 8. Date of Bir (Month, Da Dec. 2	Day C4 4c. Cou	Year 2006 unty of Death 1000 9. Birthy Cour	3. Time of Death 2:15 PM Out Diace (State or Foreign Md
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural; or Itama 23a or 28a-f show event, Ira Medical Exacultation in the confiled at Be Completed by Funeral Director	1	Suel Residence of Decedent	Venue 12. Was Decedent Ever in Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	16a. Dece (Give life.	10f. Zip Code	Specify: ation furing most of work)	ing	US Spe Spe Baltir Lat	of What Cour A Race - Americ Black, White, pocify: Black of Business/In nore C:	ean Indian, etc. ack dustry ity
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then any Injury or other traumatic event, Item once. To Be Comp	2	James Bond, Sr 19a. Informant's Name/Relationship (7) Hannibal Mickens 10a. Method of Disposition 11x Burial 2 Cremation 3 Comparison 1 Comparison 2 Comparison	- Son 20b Removal from State	3672 Place of Dispo cometery, cre ing Memo	ng Address (Street a 2 Forest B sition (Name of matory or other place prial Park 2. Name and Addres	and Number or Rur Hill Road B) 5-16	Balto Date -2006 Larch F/	er, City or To Md 2 20c. Location Randa H Wes	21207 on - City or To a11stov st	own, State
Hitcate be executed by physician and list the burial-transit street burial-transit edical Examiner		23a. P. fit. Ent in the disease, or comp shock, or heart failure. List only of mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions, if any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last	b. Due to (or as a cons	rotic (requence of): Nemore of): Av		cerlar	Digeo			Approximate Interval Between Onset and Death
the death certification of the attending place of the death of the dea		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 5 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fo 4 Pregnant at time o 9 Unknown	etal death 3[Ectopic pregnancy Other (specify)	-		23d.	Date of delive	ery Day Year
has been signe	F	art II. Other significant conditions or	ontributing to death but not r	resulting in the u	nderlying cause give	en in Part I.	1 🗆 24a. Was	Yes 2 XNo an 24 psy prmed?	b. Were auto	psy findings availabl impletion of cause of
ng Physician Iter this certifi ineral director on; To Be	L	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day Year)	t home, farm, st	f 28c. Injury Work M 1 🗆 Y	Nursing Ho	ome 5 Resi	dence 6 dence	Other (Specificurred	2 No No No Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu Medical Certificati	L	29a. Certifying Phy	ysician: To the best of my k iner: On the basis of exami and manner stated.	rnowledge, deat	29c. License	pinion, death occur number	and due to the red at the time,	cause(s) and date and place 29d. Date sig	ned (Month,	Day, Year)
State Begistrar		Rame and address of person who of Ramesh Sa Dape Part Part Part Part Part Part Part Part	completed cause of death (III	09 Bac	Print) RIVE	Neck	Road	d Bal	hmon	200 6 Mayland 2121

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ORIGINAL

06-02986 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Rema Matthew * 1. For State Certificate of Death Reg. No Registrar 2. Date of Death . Decedent's Name (First, Middle, Last) Physician/ 2346 hrs **Medical Examiner** May 2, 2006 Matthew Remema 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Baltimore** Union Memorial Hospital If Under 1 Year If Under 24Hrs. 8 Date of Birth (MM/DD/YYYY 9. Birthplace (State or Age (In yrs. last birthday) 5 Social Security Number **Funeral** Foreign Jamaica Country) Months Days Hours Min Director 56 06 10 49 216-04-5591 M 2**X** F Yrs Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a. State 10h County 1 X XYes 2 No 28a-f show Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene and: If item 27 is marked other than "natural", or items 23a or 28a-f sho NA MD Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code notified at U.S.A. 21215 4539 Lanier Ave Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status must be Armed Forces? White, etc. 1 Never Married 2 X Married Yes 2 X No Black f Yes, Give Year Yes 2 No specify: Specify Divorced Widowed <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) marked other than "s c event, the Medical E Baltimore, MD 21215-0036 Housewife Home llth grade na 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ina William æ Elijah Cherrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4539 Lanier Ave, Baltimore, Md Lionel Matthew-Husband nt: If item 2 other traus 20b Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Important: I 5/17/06 Baltimore, Md Donation 5 Other Specify Metro Crematory Inc. 21. Signature of Juneral Service Licensee March F/H West a 21215 Approximate Interval 4300 Wabash Ave, Baltimore, Md 23a, Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Cardiac arrhythmia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X UNPENDED AMENDED item#1,23a,PII,27,perME,g857,7/6/06 TT attending physician or use as the burial certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed by ģ Yes 2 No 3 Probably 4 ✔ Unknown Mild Bronchiolitis Completed 24a. Was an 24b. Were autopsy findings available After this certificate has been autopsy prior to completion of cause of death? performed' page 2 ✓ Yes 2 1 V Yes 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Be Other₄ examiner? Inpatient Nursing Home 5 Residence 6 Other: 2 ER/Outpatient 3 1 V Yes 2 ۵ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 5 Pending To the Funeral Director: filled in by the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29d Date signed (Month Day Year) 29b. Signature and title of certifier O.C.M.E. May 3, 2006 mo 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed Month Day Year 2006 32. Registrar's Signature

State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** John Kenneth McAuley 2:37 p.mM May 15, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Landsdowne Baltimore 2937 Freeway If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 52 Yrs. 219-66-3571 Director January 31, 1954 Maryland Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director Maryland Baltimore Landsdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 U.S.A. 2937 Freeway or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) re kind of work done during most of working DO NOT use retired) Carpentry Efementary/Secondary (0-12) Coflege (1-4or 5+) nd Mental Hygiene. marked other then Carpenter 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental Nadia Jean Ebert John Westlyn McAuley 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 162 Lourier Dr. Westminster, Maryland 21157 Mrs. Ellen Daihl Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/18/2006 Poplar Springs, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Poplar Springs Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A 1400535 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Impediate Cause (Final disease or condition resulting in death) **Physician** METASTATIL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Records, P.O. Box 68760, $\mathcal C$ The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 Yes 2 No Division of Vital nours after death.

nerel Director: After this certific
filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Certification: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and the of certifier D18587 who completed cause of death (Item 23a) (Type, Print) AUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Acart. Registrar

Kench

Joan

			For State Registrar	State of Ma	aryland		artment o			ind M		and the same	006	15509
	Dhusisi		1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month		Yeer	3. Time of Death
	Physici /Medic		THOMAS					IORR			05	10	2006	6:50 AM
	Examin	er	4a. Facility Name (If not institution, give s				4b. City, To			f Death				1
			FOREST HILL HEALT 5. Social Security Number 6. Sex		B CENT le (In yrs. la		FORE		HILL If Under 2	24 Hrs. 1	8. Date of Birt	Ath Day Yeer 10 2006 4c. County of Death HARFORD The Year 922 Accounts of What Country USA 10g. Citizen of What Country USA 14. Race - American Black, White, etc. Specify: White 16b. Kind of Business/Indu US GOVERNING Maiden Sumame) 10g. City or Town, State, Zip Country White 16b. Kind of Business/Indu US GOVERNING Maiden Sumame) 10g. City or Town, State, Zip Country or Town, State	place (State or Foreign	
L	Funeral Director				83	Yrs.		ays	Hours	Min.	Aug. 26	, Year) 922	2 Mar	yland
	land ow		10a. State 10b. County	-	10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Many s-f sh	to	Maryland Harfor	rd.		Aberd	een							XXYes 2 ☐ No
	or 284	Director	10e. Street and Number				10f. Zip Co					-		intry?
	23a	ai	700 West Bel Air A	Ave. Apt.	202			2100)1			USA		
	tems tems	Funerai		Was Decedent Armed Forces?		5. 13.	Was Deceden If Yes, specify	t of His Cuban	panic Orig , Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. F		
36	s afte	by F	Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 □ If Yes, Give Year or Dates:	No		1 □ Yes 2 □	No	Specify:			Spe	city: Wh	ite
21215-0036	d within 72 hours after death with the Maryland liene, r than "naturel", or Items 23a or 28a-f show the Medical Examination must be notified at		15. Decedent's Educ			16a. Dece	dent's Usual C	Occupat	ion			16b. Kind o	Business/I	ndustry
15	n n	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5.1)	(Give	kind of work of DO NOT use	done du	iring most	of workii	ng			
212	d within giene. er than	Completed	12	0	3+,	ci	vil se	rvic	ce			us g	govern	ment
	be filed ntal Hygie ad other avent, It	Be (17. Father's Name (First, Middle, Last)										ame)	
yla	should be ind Mental i marked c	၉	Thomas J. Morris,								Hession			
Maryland	01 00 00 00	1 3	19a. Informant's Name/Relationship (Typ											p Code)
	s 1 and 3 if Health itam 27 other tre		Dolores Kesling (ni 20a. Method of Disposition	Lece)	20b. Pla	ace of Dispo	sition (Name	of			ate			own. State
JO.	Pages nent of ont: If it ury or o		1 Burial 2 □ Cremation 3 □ Roy 4 □ Donation 5 □ Other (Specify)	emoval from State		metery, cra .awn C	emeter	r place	5	/13/	06			
Baltimore,		l i	21. Signature of Funeral Service License			22	2. Name and	Address	1					
Ba	permit. Depart Import any inj		Mara C.	Belli	na	IIA	perdee	1, 1	штут	anu	21001-3	1333	neral	
			3a Part1. Enter the disease, or comble shock, or heart failure. List only on Immediate Cause (Final	e cause on each li	ne.	. Do not en	er the mode o	ar arying,	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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0,	be exerician ar burial-t		resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	ate hys	dicai	d											
9 X	eath certific attending pl	hysician/Medi	IF FEMALE:	3c. If yes, outcome	of pregnan	icv			_			224	Data of dalis	ann.
Вох	atten I for u	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[Ectopic preg							Day Year
0	the d by the achec	hysi	1	9□ Unknown										
٥,	law requires that the de as been signed by the a 2 should be detached t	by P	Part II. Other significant conditions con	tributing to death b	out not resul	lting in the u	nderlying caus	se giver	n in Part I.		23e. Did to	becco use c	ontribute to	the cause of death?
ıd	en sig										1 🗆 Y	′es 2□No	3 □ Pro	bably 4 DUnknown
Records,	law requas been 2 shoul	ompleted									24a. Was autop			opsy findings available ompletion of cause of
<u> </u>	ian: The la rtificate ha stor, page 3	Con									perfor	med?	death?	No
Vital	ician: certific rector,	Be	25. Was case referred to medical examiner?					_	*	of Death	(Check only o	ne)		
of	Phys this al di	2	1 Yes 2 No	ospital: 1 ☐ Inpation		R/Outpatier 28b. Time o		Other	4 Nui					ify)
		tion	1 Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	M 200	Mork?	ai P es 2.⊟N	1	ou. Describe ii	low injury occ	urrea	
Division	deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At hon	ne, farm, str				-			mber or Rui	al Route Number,
Ö	iel or Attendi s after death. al Director: A ad in by the fu	Certification:	4 Homicide	building, et	tc. (Specify)						City or Ton	m, State)		
	Hospit 4 hour Funera ely fille	edical C			f examinati									
	To the I within 2. To the I complet	₩ E	29b. Signature and title of certifier				29c. L	icense	number			29d. Date sig	ned (Month	Day, Year)
			1 Daw 5	D.				03	2-25	55		MA	, 10	2000
	1		30. Name and address of person who co				Print)			-				
	1							E 10	06, E	BEL A	IR, MD	2101	4	
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 7 2006	32. Registr	rar's Signatu	ILE OF								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** May 12, 10:00PM Donald B. Mainwaring 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Hospice Casey House Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F Months Days Hours 78 Yrs. 1927 053-20-5059 July 6, New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 10a. State rthen "natural, or Iteme 23a or 28a-f ehow Ine Madical Examinar must be nutified at 1 ☐ Yes 2X No Maryland Montgomery Potomac Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20854 United States 8803 Tallyho Trail death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No World If Yes, Give Year or Dates: War II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. Commercial Airlines Pilot permit. Pages 1 and 2 should be filed w Depertment of Heelih and Mental Hygier importent: If item 27 ie marked other the eny injury or other traumatic event, ITEM 2002. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Iva Spencer ဂ္ John Mainwaring 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 8803 Tallyho Trail, Potomac, Maryland Jeanne Mainwaring/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 16, 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Montgomery Bethesda, Maryland Pumphrey Funeral Home/ 7557 Wisconsin Avenue 4 ☐ Donation 5 ☐ Other (Specify) 2006 Cremătoriúm, Inc. 22 Name and Address of Facility Robert A. Pum Bethesda-Chevy Chase, Inc. 755 Bethesda, Maryland 20814-3501 21. Signature of orieral Service Licens e M00803 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non Hodgkins Lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to finite claste cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to lorge a consultience of Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year After this certificate has been signed by the ette funeral director, page 2 should be detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MN D35635May 15, 2006 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland Joseph Kaplan, M.D. 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 7 2006 Registrar

06-03255 Percy Patterson

Please Type or Print in Black Indelible Ink
State of Marvland / Department of Health and Mental I

		1. For State Registrar State of Wai yland / Department Certificat	nt of Health and Mental F te of Death	_	200	100
Physic Medical Exan	ian/ nine	Hercy tatterson		2. Date of Dea Month May 14, 2	Day Year	3. Time of Death
		Aa. Facility Name (if not institution give street and number) 2031 Frederick Avenue	4b. City, Town, or Location of Deat Baltimore	h	4c. County of Deat	t .
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd: 1 Usual Residence of Decedent		A	th (MM/DD/YYYY) 9 Bir F, 1957 Foreig	
ith the Maryland 23a or 28a-f show any notified at once,	Director	10a. State 10b. County Mayland NA 10c. City, Town or 10c. Str et and Number	Battimere 10f. Zip Code	110	Og. Citizen of What Cour	10d inside City Limits 1 Ves 2 No
hours after death w "natural", or items Examiner must be	by Funera	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	3. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban Mexican, Puerto 1 Yes 2 No specify Redent's Usual Occupation (Give kind of ving most of working life. DO NOT use reti	Rican, etc.)	14. Race - Ameri White, etc Specify.	ack
21215-00 ould be filed win Mental Hygier marked other	To Be Completed	17. Father's Name (First, Middle, Last) Willie Taylor 19a, Informant's Name/Relai onship (Type, Print) 19b, M.	18. Mother's Name	Mae t	dmonds	
Ore of H		20a. Method of Disposition 20b. Place of Di	ailing Address (Street and Number or F	Date 20-06	per, City or Town, State, 100 C. Location - City or T	Zip Code) 11233 Coden State
Baltim, permit Pag Department Important: Important: injury or of		24 Cinnet (Cinnet)	22. Name and Addres of Facility 35 72 Fruit Like Item the mode of dying, such as cardiac or	e-Fu respiratory arres	att mp ~ /	Mary land Parity 21339 Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death) a Narcotic intoxication of Due to (or as a consequence of):				Between Onset and Death
Sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last b				
freate be executed by physician and the burial - transit	/Medical E	XUNPENDED amended item#23a,27,28a	-f,perME,g856,6/23/06 T	T		
30x 68 death certine ne attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnan		23d. Date of delivery Month Da	y Year
P.O.	Completed by Pi	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	1 Yes	acco use contribute to the 2 No 3 Probab	oly 4 Unknown
tal Rec cian: The la certificate h	Be Com	25. Was case referred to medical examiner?	26.Place of Death (Check on	autopsy performe 1 Yes 2	2017 Maath2	pletion of cause of 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been side in by the funeral director, page 2 should b	유.	1 V Yes 2 No	ent 3 DOA Other Nursing of Injury 28c. Injury at Work? 2 30 am 1 Yes 2 X No		sidence 6 🗸 Other: Si	cene
Divi	Ser	Suicide 4 Homicide 6 X Could not be determined (Specify) Found: resider (Specify) Certifying Physician: To the best of my knowledge, death occurrence) 28e. Place of Injury - At home, farm, st (Specify) Found: resider	nce B	altimore,	et and Number or Rural	Route Number, City
To the Howithin 24 For the Function Completely	g G	me) 2 Medical Examiner: On the basis of examination and/or investigand manner stated 9b. Signature and title of certifier	gation, in my opinion, death occurred at the 29c. License number	ne time, date and) and manner as started I place, and due to the ca ed. Date signed (Month,	
Br.	3	0. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.	1.	May 15, 2006	uay, rear)
Sta		Patricia Aronica-Pollak MD. Assistant Medical Examiner 1. Date filed (Month, Day, Year) 32 Registrar's Signature	111 Penn Street, Baltimore,	MD 21201		
Registr	ar	MAY 1 7 2006 Mayer & Ja	the same of the sa			
HMH 17 Rev 1/200 CME 2006	01	ORIGIN	ΔI			

			State of Maryland / Department of Health and Men	ital Hygiene	2006 55 2
			1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. I	Reg. No Date of Death	3. Time of Death
* 8	Physicia /Medic	an al	Mary V. Pelczar	Month Da Nay 15	2006 9: 20 AM
1	Examin	5 5	4a. Facility Name (If not institution, give street and number)	nove 10	:. County of Death n/a
. 4	Funeral	200			
14	Director		212-40-2258 1 M 2 F 97 Yrs. Months Days Hours Min. No.	Date of Birth Month, Day, Year V 24, 19	08 Maryland
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Maryli fed	tor	Maryland n/a Baltimore		1 X Yes 2 ☐ No
	h the	Director	10e. Street and Number		itizen of What Country?
	23a c	alD	3300 Benson Avenue 21227		ted States
396	s within 72 hours after death with the Maryland liene. I then "netural", or items 23s or 28s-f show then "madical Examiliser, wat be notified at the Madical Examiliser, wat be notified.	by Funeral		r Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. h	Kind of Business/Industry
121		Completed	Elementary/Secondary (0-12) O College (1-4or 5+) homemaker	h	ome
9	Hyg Hyg sthe	ေ င၀	17. Father's Name (First, Middle, Last)		n Sumame)
<u>lan</u>	\$ 5 5 9	To B	John Pfaifer Louise G		
Maryland 21215-0036	12 shown and 7 iem.		19a. Informant's Name/Relationship (Type, Print) Michael E. Pelczar, M.D. – son 19b. Mailing Address (Street and Number or Rural Run, Queenstown) 133 River Run, Queenstown	oute Number, City n, Maryla	or Town, State, Zip Code) .nd 21658
re,	- I = =		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		ocation - City or Town, State
imo	nit. Pages artment of ortant: if it injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Stanislaus Cemetery 5/17		
Baltimore,	permit. Page Department Important: if eny injury or		21. Signature (1) Inerat Service Livensee 22. Name and Address of Facility Hubba 4107 Wilkens Avenue,	Baltimor	e, Maryland 21229
•			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death
1	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death) a	14	1 year
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	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	diseas	e years
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687	fficate g phys	edic	O		
Вох	death certifica attending pt afor use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.O.	y the a	yslo	1 Tes 2 Tho 9 Unknown		
	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	a Harris of the significant continuous conti	23e. Did tobacco	ouse contribute to the cause of death? 2 No 3 Probably 4 Unknown
900	e law requin has been si ge 2 should I	Completed	Chronic back pain	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E B	The rate has page	Com	E CO	performed? 1 ☐ Yes 2 X	death? 1 Tes 2 No
Vita	ician: cartific	Be	25. Was case referred to medical 26. Place of Death (C		C Dothor (Charife)
o	Attending Physician: r death. ector: After this certifici by the funeral director, i	. To	T Tes Z ANO T Impatient Z EP/Outpatient 3 DOA 4 All Mullish House	d. Describe how in	6 Other (Specify) ury occurred
ion	ath. rr: Afte	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
Division of Vital Records,	i or Atte after de Directo	Certification:	3 Suicide 4 Homicide Suicide 4 Homicide Suicide Suicid	Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	due to the cause(at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within To the comple	Me		29d. D	Pate signed (Month, Day, Year)
			my 000 055391	Mo	y 15, 2006
H			30 Name and address of person who completed cads of death (Item 23a) (Type, Print) Ming V, 3320 1 Ens m + venue. Baltim	ure, N	Caryland 21227
	St Regist	ate	Toolse a Michael Toolse Michael Michae		1
1	- 109131		HIM I I LOUD RESIDENCE		

06-02507 Please Type or Print in Black Indelible Ink Terrance Randolph State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 12, 2006 1806 hrs Medical Examiner Terrance Randolph 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death rear of 1900 block Division Street **Baltimore** 5. Social Security Number unk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director 1 X M 2 F Oct 15, 1986 19 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 X Yes 2 No 28n-f show , or items 23a or 28a-f show imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk 3809 C<u>larks Lane</u> #205 21216 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12, Was Decedent Ever in U.S 11. Marital Status Race - American Indian, Black. unk unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc 1 Never Married 2 Married Yes 2 No item 27 is marked other than "natural", traumatic event, the Medical Examiner. Divorced If Yes, Give Year or Dates: Yes 2 X No specify: Specify: black ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) unk 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Baltimo
permit. Pages
Department of Donation 5 X Other Specify: in state 21. Sign rule of uneral Service Licensee
Ronald S Wade, Director
State Anatomy Board 655 W. Baltimers. MD 21201

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of icate has by page 2 sh performed? death? certificate 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene this ٩ 1 ✓ Yes 28a. Date of Injury FOUND: Pay, Year) After 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Subject assaulted FOUND: Division 1 Natural Yes 2 V No within 24 hours after death.

To the Funeral Director:
completely filled in by the f Pending Apr 12, 2006 1801 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) rear of 1900 block Division Street, Baltimore, MD determined (Specify) Alley 4 V Homicide 29a. Certifier cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: Op th the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co APRIL 17, 2006 O.C.M.E. addr s of pe completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiulah Ali, M.D. Assistant Medical Examiner

Registrar
DHMH 17 Rev 1/2001

OCME 2006

State

31. Date filed (Month, Day, Year)

ORIGINAL

2. Registrar's Signature

			For State Registrar	S	tate of	Marylan		rtmen tificat			ınd M	ental Hy	giene Reg. No20	06	15514
	Physicia /Medic		1. Decedent's Name (First, M Eric Russell	iddle, Last)								2. Date of De May 10		Year	3. Time of Death 11:45P M
	Examin		4a. Facility Name (If not instit 301 Hospital		et and numb	er)			Town, or 1 Bur	Location o	f Death		4c. County Anne A	_	el
	Funeral Director		5. Social Security Number 216–12–8412		2 F 7.	Age (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Birt Maly 0,	n 959	9. Birthi	place (State or Foreign ontry MD)
Maryland	a-f show iffied at	ctor	Usual Residence of Decedent 10a. State 10b. Con MD Anne		el		y,TownorLo n Burni								10d. Inside City Limits 1 □Yes 2√√No
h with the	23a or 28 at be no	Funeral Director	10e. Street and Number 301 Hospital	Dr				10f. Zip	Code 061				10g. Citizen of V USA		ntry?
U Z I Z I J-0000 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event. It Medical Examinar must be notified at once.	by	11. Marital Status XX Never Married 2□ 3 □ Widowed 4 □ Divo	Married	Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	∏.No		Was Deced I Yes, spec I ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Rac Blac Specify	ck, White,	can Indian, etc. Lack
d within 72 hc	giene. sr than "natur the Medical	Completed	15. Dece (Specify only hi Elementary/Secondary (0- N/A		on ompleted) College (1-4	or 5+)	16a. Deced (Give life. L NOT	kind of wo DO NOT us	k done d	urina most	of worki	ng	16b. Kind of Bi		dustry
2 should be filed with	dental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Mid Joseph White	dle, Last)						18. Mothe Bett			Maiden Surnam	ne)	
and 2 sho	alth and h 27 is ma or trauma		19a. Informant's Name/Relat		Print) ther							/ <i>Route Numbe</i> ore, MD	or, City or Town, 21206		Code)
Pages 1 a	nent of He int: If Item iry or othe		20a. Method of Disposition 1 🛣 Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe		oval from St		lace of Dispo emetery, cren Calvar	natory or o	ther place	y M		6, 2006	20c. Location - Balti		
permit.	Departn Importe any inju		21. Signature of Funeral Ser	rus C	MO	148		Name an				1 ^P .ABur	nie, MD	210	061
23a. Part Enter the disease, or complications the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death		
1	Medical kaminer		disease or condition resulting in death)	1	Due to (or	as a consequ	uence of):	N	10	F	720	(Ra)	non	_	
e be executed	attending physician and I for use as the burial-transit	si Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1		as a consequ									
A OO A	ding physi se as the l	/Medica	IF FEMALE:	d	If yes outco	me of pregna	nov.						224 2		
The law requires that the death certificate	been signed by the attendin should be detached for use	Physician/Medical	23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown	200.	1 Live birt	h 2 ☐ Fetai nt at time ol de	death 3	Ectopic pr Other (sp						te of deliventh	Day Year
v requires tha	en signed ould be de		Part II. Other significant con	ditions contrib	outing to dea	th but not resi	ulting in the ur	nderlying c	ause give	n in Part I.			obacco use cont (es 2 No		he cause of death? pably 4 □Unknown
	s certificate has be director, page 2 sh	Completed by	Let Ro	100	40	7 5	Je 5	2	•			24a. Was autop perfo 1 Yes	med?	Were auto prior to co death? I Yes	psy lindings available mpletion of cause of
To the Hospital or Attending Physician:	the le	ion: To Be	25. Was case referred to me examiner? 1 Yes 2 To 27. Manner of Death 1 Attural 5 Pe	Hos	pital: 1 Inp 28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		8c. Injury Work	r: 4 □ Nui	rsing Hor		ne) dence 6 Oth now injury occurr		y)
DIVISION I Or Attend	within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Certification:	3 ☐ Suicide 6 ☐ Co	estigation ould not be termined	28e. Place o building	f Injury - At ho , etc. (Specify	ome, farm, str					281. Location (S City or Tow		er or Rura	al Route Number,
e Hospita	24 hours a Funerel letely filled	edical C	29a. Certifier 1 Cert (Check only 2 Med	ifying Physici ical Examiner	an: To the b : On the bas and manne	is of examina	wiedge, death tion and/or inv	occurred restigation	at the tim in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) and ma date and place,	inner as s and due to	tated. o the cause(s)
Toth	within To th compl	Me	29b. Signature and title of ce	rtifier	ees	mle		290	License	number S	3		29d. Date signed	(Month,	Day, Year)
			30. Name and address of per ROINKI B. i		rick.	6ltr	Bur	Print)	M)					
	Sta Registi		31. Date filed (Month, Day, V	7 2006	3 Reg	gistrar's Signa	ture	de							

State of Maryland / Department of Health and Mental Hygiene 2 0 6 For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RICHARDSON 4:35 AM 2006 MAY /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner COLUMBIA GSAWOH COUNTY GENERAL HOWARD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 11 M 2 1 F Yrs. Director 408-10-9912 07/12/1915 Tennessee Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 27 is marked other then "natural", or Itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XNo Director Howard EllicottlCity 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3363 North Chatham Road 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. e filed within 72 hours after of Hygiene.
Other then "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify: Completed by Specify: White 3 □XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker None permit. Pages 1 end 2 should be file. Department of Health and Mentel Humportant: If ten 27 is med eny Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Fayne Wilhoit Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2214 Arapahoe Avenue, Catonsville, Maryland 21228 of Disposition (Name of Date 20c. Location - City or Town, State Roger F. Richardson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Memorial 05/12/2006 Glen Burnie □Donation 5 □Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician NEUMONIA DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). The law requires that the death certificate be executed anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CUTHEOUS T-CELL LYMPHOMA DEEP VEIN THROM-2 XNo 3 ☐ Probably 4 ☐ Unknown Completed DIABETES OF RIGHT MELLI TUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No မ 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation verel Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funerel I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38296

Registrar DHMH 17 Rev 1/2001

State

Book

8186 LARK BROWN RD, SUITE 201, ELICRIDGE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2006

32 Registrar's Signature

JOSEPH GIBBONS MD

MAY 1

31. Date filed (Month, Day, Year)

			1 - State Registrar Amend Item	State of N	Marylan	d / Depa	artment <i>titicate</i>	of H	ealth a	and M		21	106	15516
\$	Physici /Medi		1. Decedent's Name (First, Middle, Las Frances Beatric	")				JH-			2. Date of De Month May	ath Day	Year 2006	3. Time of Death 11:50 PM
	Examir		4a. Facility Name (If not institution, give 8733 Warm Waves	Way			(Colu	Location o			Reg. No. 2006 Death Day 2006 4c. County of De Howar 19, 19, 19, 19, 19, 19, 19, 19, 19, 19,	ward	
**	Funeral Director		5. Social Security Number 249-44-4626 Usual Residence of Decedent	x 7.7	Age (In yrs. 7	7 Yrs.	If Under Months	Days	If Under: Hours	Min.	8. Date of Birt (Month, Da Dec. 1	7,1928	9. Birthp Cour Sout	place (State or Foreign http:// th Carolina
	e Maryland	Director	S.C. 10b. County Abbevill	e	10c. City	y, Town or Lo	cation eville	9					1	0d. Inside City Limits 1 Yes 2 No
	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow deal Expranter much be motified at	Funeral Dire	10e. Street and Number 504 Vienna Street 11. Marital Status	t 12. Was Decede	nt Ever in II	S 13 1	10f. Zip	2	9620	ain? (Sa			U.S.A	1.
9036	ours after d iral', or Item Exercises	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? <mark>X</mark> No	ľ	f Yes, speci		Specify:	, Puerto	ecify Yes or No Rican, etc.)		ck, White,	etc.
21215-0036	within ane. then	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)		or 5+)		lent's Usual kind of work DO NOT use	k done d e retired)	luring most)		ing			
Maryland 2	be filed htal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Unknown			Bello	JI Adii		18. Mothe	r's Name	(First, Middle, Coleman	Maiden Suman		LOII
	nd 2 shillith and 27 le m		19a. Informant's Name/Relationship (7) Carol Strickland	ype, Print) (Daught		8733	Warm	Wave	es Wa	y C	olumbia	, Maryl	and 2	21045
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑ 4 ☑ Donation 5 □ Other (Specify)			tace of Dispo emetery, cren ke Univ	versit	Э		5-4-	2006	Durham	, N.C	3.
Ba	Depertr Depertr Importu eny Inje		21. Signature of Funeral Service Lichns 23a. Part1. Enter the disease, or comp	lications that caus	ed the death	n. Do not ente	Vitzke	Win	neral Knol	Hom 1s R	es, Inco	iumbia,	Mary	rland 21045
	/Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	as a consequ	0 (8)		,			ailure			Interval Between Onset and Death
**	Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	b. Due to (or s	is a consequ	uence of):								
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Division of Vital	To the Hospitel or Attending Physician: The within 24 hours attendeath. To the Funerel Director: After this certificate completely filled in by the funeral director. pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 2 Accident 2 Accident 2 Accident 2 Accident 3 Accident 3 Accident 4 Accident 5 Accident 6 Accident 6 Accident 7 Accident 7 Accident 8 Accident 8 Accident 9 Accident 9 Accident 10 Accident 10 Accident 11 Accident 12 Accident 13 Accident 14 Accident 15 Accident 16 Accident 17 Accident 18 Accident 18 Accident 19 Accident 10 Accident 11 Accident 12 Accident 13 Accident 14 Accident 15 Accident 16 Accident 17 Accident 18 Accident	1 Inpa 28a. Date of In (Month, D	ijury	ER/Outpation 28b. Time of Injury		c. Injury Work	r: 4 🗆 Nur	sing Hor		ence 6 XX th		Paughter's Home
Divis	Itel or Attendus after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined		etc. (Specify	')					City or Tow	m, State)		
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	F 3 F 8		30. Name and address of person who co	p leted A a of	death (Itam	23a) (Tvna 1	Print)	Dz.	1/F	1		mc/	4 1	2346
2 -	D° Sta	ite	31. Date filed (Month, Day, Year)	24. Regis	strar's Signat	ture	116	#	ch	Fo, 1		Colone	5	Mary low
4	Registr	ar	MAY 1 7 2008	Maye	J. K.	1500								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** JUMADA 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cjty, Town, or Location of Death 4c. County of Death Examiner /AmedicaL NIA BALTIMORE LtimuRe Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** -36 1 M 2 F 75 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Tes 2 No **Funeral Director** Marylan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Black, White, etc. Forces? Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. No Pes 2 No No Pear or Dates: 1 Never Married 2 Married Specify: 13 1 Yes 2 No Specify: ac Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SCM Chemical aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) int of Health a t: If Item 27 le y or other trau tha more 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Hum ral Service Loghs e 22. Name and Address of Facility 3512 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760; ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy 217 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Pate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Seath 28d. Describe how injury occurred t Natural 5 Pending investigation death. after death | Director: A d in by the fi 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours afte To the Funerel Dir completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elno

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Registrar's Signature

		-	State of Maryland / Department of Health and State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health and Person State of Maryland / Department of Health And Person State of Maryland / Department of Health And Person State of Maryland / Department of Health And Person State of Maryland / Department of Health And Person State of Maryland / Department / Depar	d Mental Hy	giene 2	005	15518
	Physicia	an	1. Decedent's Name (Fiss) Middle Last EPERSAD	2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL OF BALTMORE BALTIMORE		4c. Count	ty of Death	
	Funeral Director	F	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 4. Months Days Hours M 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Months Days Hours M		ay, Year)	Cour	place (State or Foreign ntry) NIDAD
	Aaryland I show	Ī	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD NA BALTIMORE			1	10d. Inside City Limits 1X Yes 2 No
	with the N a or 28a-1 be notiff	Direct	10e. Street and Number 10f. Zip Code 3937 CLARKS LANE APT • A 21215		10g. Citizen of		
₹ °°	fier death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 1 Yes 2X No	(Specify Yes or Nuerto Rican, etc.)	o- 14. Ra Bla	ace - Americ ack, White,	can Indian, etc.
JATTAN 5-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-1 show Iteal Exerctor court by notified at	Completed by	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify, only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of year)	working	Speci		INDIAN
121	1	Compl	Elementary/Secondary (0·12) 5th 17. Father's Name (First, Middle, Last) College (1·4or 5+) NA JANITOR 18. Mother's Name (First, Middle, Last)	Name (First, Middle		DEAL	ER
PERSAD Maryland 2	2 should be filed withir and Mental Hygiene. Is marked other than sumetic event, the M	To Be	() () dation of the order of th	LWA SARO	OOPEAH		p Code)
SEEPEaltimore, Ma	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marks any injury or other traumatic ones.		MAHADAYE SEEPERSAD - wife 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Qonation 5 Other (Specify) METRO CREMATORY 3937 CLARKS LANE 20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY	APT A 17/2006		ORE,	MD 21215 own, State
Baltir	permit. P Depertme Importan any injur		21. Sign fun of Funeral Service Licenses AND	ME WEST,	INC		
	Physician /Medical Examiner	her	23a. Part Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as card shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. IN TRA CRANIAL HEMOLING E	diac or respiratory	arrest,		Approximate Interval Between Onset and Death 3 weeks
760,037	ate be executed hysicien and the burial-transit	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.				
Division of Vital Records, P.O. Box 68760	or Attending Physicien: The law requires thet the death certifica fler death. Director: After this certificete hes been signed by the attending ph in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown			ate of deliv Month	rery Day Year
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of Vita	hysician: his cartific I director,	To Be	examiner? 1 Yes 2 No	Death (Check only	sidence 6 🗆 O		(y)
/ision o	f or Attanding Physician: The lefter death. Diractor: After this certificate he I in by the funeral director, page	Certification:	27. Manner of Death 1 Natural	28f. Location	(Street and Nun		al Route Number,
٥			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl	lace, and due to the	e cause(s) and r	manner as	stated.
	To the Hospitel within 24 hours of To the Funeral completely filled	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated. 29b. Signature and title of fertifier 29c. License number	occurred at the time	29d. Date sign		
	4		M·ID RES - OUC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				2006
	Sta	ate.	JOHN NWANKWO MD SINAI HUSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature	OF BA	LTMORE	,	
	Regist		MAY 1 7 2006 Some & Spark				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Amend Item #8 Per FH g855 59 esificate pf Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, M. Mal 920 M thzoob County of Death 4c. 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howen (In yr last birthday, de olumbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Say, Year) Dec 23, 1934 (State or Foreign 5 Social Security Number 9. Birthplace Country) Days Hours Min 1934 West Virginia 235-52-5097 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2XNo Laurel Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9047 Old Scaggsville Road USA 20723 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, While, elc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married 1☐ Yes 2☐No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Property Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Company Co-Owner & Operator 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Olin Frederick Smith Margaret Pauline Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Lee Smith/Wife 9047 Old Scaggsville Road, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Aremoval from State Ruddle Cemetery 5/20/2006 Ruddle, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Ucensee 313 Talbott Avenue, Laurel, MD 20707 M00160 anlelde Approximate Interval Between Onset and Death 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due Consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 1 Yes 1 TYes 21 26. Place of Death (Check only one

Physician /Medical Examiner The law requires that the deeth certificate be executed and

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

or then "natural", or items 23a or 28a-f ehow The Medical Examinar must be notified at

72 hours after

12 should be filed within In and Mental Hygiene.
7 Is marked other then "1

other traumatic event,

permit. Pages 1 and 2.
Department of Health a Importment if Item 27 le any Injury or other tratonce.

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

Attending Physician:

Director

Funeral

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Completed

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physicien and s the burial-trans use as the ettending ŏ signed by the ed been rector, page 2 s within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, To the Hospital or

Physician/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by To Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 Tes 28a. Date of Injury (Month, Day 8b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Medical Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No -2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 [] Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as success.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of Pertifier

State Registrar

31. Date liled (Month, Dey, Year) 7

MAY

2006

30. Name and



who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 4:10 P M May 11, 2006 Frank J. Szpara Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12705 Orchard Drive Talbot Cordova If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F Yrs 3-21-1923 Director 83 183-14-4590 PA Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 23e or 28e-f show Important: If item 27 le marked other then "natural; or Items 23e or 28e-f show any injury or other treumatic event, it a healtest mantal ternofilitied. 1 ☐ Yes 2 X No Director MD Talbot Cordova 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12705 Orchard Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White þ Specify: 3 √Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer Oil/Petroleum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3949 Seipps Rd, Federalsburg, MD 21632 Frank J. Szpara Jr, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State TBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Meadowridge Cemetery ! 5-15-06 Elkridge, MD 21. Stratur L. Furge Samuel Traces 22. Name and Address of Facility
Fink Funeral Home P.A 426 Crain Hwy S, Glen Burnie, MD MO1148 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) uno Physician UPAC /Medical Due to (or as a cons nce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? Division of Vital Records, þ 1 tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 MG 1 Yes 2000 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 5 sesidence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred el or Attending P s after death. After 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel c within 24 hours af To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L 0.3 NARRE 100 B Amble 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland						
		1 _ State	State of Maryland		rtificate of			211116	15521
		1. Decedent's Name (First, Middle, Last)		001	Tillicate of		2. Date of De	Reg. No:	3. Time of Death
Physici	an						Month	10 200°	
/Medi		Doris Sanner 4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, o	r Location of De	1	4d. County of Dea	
Examir	ner			Br		Burnie			runde/
Funeral		5. Social Security Number 8. Sex	7. Age (In yrs. la		If Under 1 Year	If Under 24 H			thplace (State or Foreign ountry)
Director		161-36-0201	M XXF 62	Yrs.	Months Days	Hours Mi	n. Dec 29	1943	PA
D		Usual Residence of Decedent							
irylar show	_	10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
8a-11	octo	MD Anne Aruno	del Seve	rn					
with the	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
yidilid X.1X.12-00000 ould be filed within 72 hours after deeth with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-1 show atte event, the Medical Examinan months motified at	Funeral Director	211 Otis Dr	O. Was December From in H.C.	40	21144	lian ania Osinina	(Casate Van an Na	- 14. Race - Am	
er de	nu.	11. Marital Status 1 Never Married 2 Married 1	2. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)	Black, Whi	
rs aff	by F	3 √ Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2√√No	Specify:		Specify:	Vhite
2 hou	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	
	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done	du <i>ring</i> most of н d)	vorking		
d with	Completed	12		Hom	nemaker			Own Ho	ome
T HE TE	Bec	17. Father's Name (First, Middle, Last)	YK			18. Mother's N	ame (First, Middle	, Maiden Surname)	
Wents Wents itic •	10		and the Company			Maı	y Andrew	S	
S S D E E		19a. Informant's Name/Relationship (Typ	e, Print)					er, City or Town, State,	Zip Code)
Deficiency in permit. Pages 1 and 2 Department of Heelth a Important: if them 27 is any njury or other tra		Donald Sanner	Son		Otis Dr,	Severn,	MD 211		
of He roth		20a. Method of Disposition 1 ☐ Burial 2-☐ Cremation 3 ☐ Re	COL	ce of Dispo netery, crea	osition (Name of matory or other place	(8)	Date	20c. Location - City of	Town, State
Pages ment of ant: if its ury or o		4 Donation 5 Other (Specify)		iew C	rematory	5-12	2-06	Balto., MI)
Dennit. Departi	1	21, Sign 1, re of Puneral Service Licen e		22 F i	2. Name and Addre	ss of Facility	РΔ		
		K. Gregory Fink	MO1148	42	6 Crain	iwy 'S, C	Glen Burn	ie, MD 210)61
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.	Do not ent	ter the mode of dying	ng, such as card	iac or respiratory a	irrest,	Approximate Interval Between
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/Medical		resulting in death)	Due to (or as a conseque	nce of):	t.	A :			0
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and trans	Саш	that initiated events c.	Due to (or as a conseque))					ung
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o cate	dicai	d.							
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atten fo u	ian	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea	leath 3[Ectopic pregnancy Other (specify)	,		23d. Date of de Month	Day Year
S a a bed	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	un 3E	_ Other (specify) _				
that the ded by	F.	Part II. Other significant conditions conf	tributing to death but not result	ing in the u	inderlying cause giv	en in Part I.	23e. Did 1	tobacco use contribute t	o the cause of death?
w requires to be signer should be	Completed by	HUDOXIC Res	miratory]	20	Villano	u	1 🗆	Yes 2 No 3 P	robably 4 Dunknown
y requ	ete	Parkinsons	1 7		10		24a. Was	34h Word	utanau findinaa avadabla
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n: The							1 ☐ Yes	2 0 NO 1 □ Ye	s 212 No
VILCII sician: ' certifica rector, p	Be	25. Was case referred to medical examiner?	ospital:	210	ot 3 DOA Oth	A.C.	eath Check only		
Physical distribution	7. To	1 Yes 2 No	28a. Date of Injury 2	8b. Time o	III JUDON	4 140121116		dence 6 Other (Spa	ecify)
offing th.: Afte	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □No		. ,	
VISION OF VICE Attending Physician: or death. ector: Atter this certific by the funeral director,	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	ne, farm, st	reet, factory, office			Street and Number or R	lural Route Number,
d in the	Certification:	4 Homicide	building, etc. (Specify)				City or To	wn, State)	
Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached to use as the burial-transit		29a. Certifier 1 Certifying Phys	ician: To the best of my know	ledge, deat	h occurred at the tir	ne, date and pla	ce, and due to the	cause(s) and manner a	s stated.
HC n 24 l	edical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	on and/or in	ivestigation, in my o	pinion, death oc	curred at the time,	date and place, and du	e to the cause(s)
Some To the state of the state	Ž	29b. Signature and title of certifier	. ()		29c. Licens		20101	29d. Date signed (Mon	0 - 1
1.		Mul Xell	W		DO	032	144	Hay 10	2006
		30. Name and address of person who con		23a) (Type,	Print)			0 /	
		300 HOSPITAL DE GL	EN BURNIE MO	3100	.1				
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ге	8				
Regist	rar	MAT I (ZUUS	53.8 Success Elle La		D.				

			For State Registrar	State of Ma	arylan			nt of He te of D		nd M	_	giene Reg. No	20	06	15522
	Physici		1. Decedent's Name (First, Middle, Inc.) Thomas J. Scar	· ·							2. Date of De Month May 13	Da	y 006	Year	3. Time of Death
je.	/Medio Examin		4a. Facility Name (If not institution, g				4b. City	, Town, or t	ocation of	Death	ray 1.		. County	of Death	0,55
L			Suburban Hospi			1 h:		thesd	a If Under 2	4 Hrs	0. B (B)]	Mont	gomer	
ı	Funeral Director		5. Social Security Number 6 040-24-2682	. Sex 7. Age 1∭ M 2□ F		last birthday) 6 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	tn 19, Year) 13	1929	9. Birthp Coun New	place (State or Foreign htry) York
	0		Usual Residence of Decedent 10a. State 10b. County		10c Cit	v. Tourn art o	antion								
	Aaryla f ehov	ŏ				y, Town or Lo								1	0d. Inside City Limits 1X Yes 2 □ No
	r 28a-	Director	Maryland Montgo	mery	Κ€	ensingt		p Code				10g. Ci	tizen of V	Vhat Coun	itry?
	th with	aiD	10225 Frederick	Avenue, Un	it 20	03	2	20895				Un	ited	Stat	tes
20	72 hours after death with the Maryland "natural", or Hema 23e or 28e-f ehow polical Examilinat mant be natilised at	by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	If Yes, Give		s. 13. \	Was Dece f Yes, spe 1 ☐ Yes		panic Orig , Mexican, Specify:	in? (Spec Puerto F	cify Yes or No tican, etc.))-		e - Americ k, White,	etc.
2-003p	2 hour		15. Decedent's	Education	War	ш	ient's Usu	al Occupat	ion			16b. K	ind of Bu	Wh siness/Ind	dustry
CLZ12	l withir lene. r then	Completed	(Specify only highest	grade completed) College (1-4or 5-5+	+)		kind of we DO NOT L Orney	ise retired)	ring most	of workin	g				ractice
<u> </u>	be filed tal Hygid d other event, the	BeC	17. Father's Name (First, Middle, La	st)					8. Mother	's Name	(First, Middle,	, Maider	Sumam	е)	
yland	_ C	7	Thomas John Sca								McCart				00005
Z Z	d 2 sh th and th is m ?7 is m traum		19a. Informant's Name/Relationship Robin J. Scanlor												code) 20895
ē,	ss 1 and 2 should of Health and Me litem 27 le mark r other traumatio		20a. Method of Disposition		20b. P	Place of Disportementary, cren	sition (Na.	me of		Da	ite			City or To	
altimor	Page nent o ant: if ury or	i	1 ☐ Burial 2 ② Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Co		Moi	ntgomei	cy i	Inc.	20	ay 17 006	-	Bet	hesd	a. Ma	aryland
Balt	permit. Pages 1 Department of H importent: if ite any injury or ot once.		21. Signature of Funeral Service Lice	essee	M008	303 Be	Name alethes	nd Address da-Ch	of Facility Levy (larv1a	Robe Chase and	ert A. Inc. 20814-	Pum 75	phre 57 W	y Fur iscor	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	the deati	h. Do not ente	er the mod	de of dying,	such as c	ardiac or	respiratory a	rrest,			Approximate Interval Between
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200		ed		d								т.			
.C. BOX	he death certifi / the attending ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal	Ideath 3	lEctopic p Other <i>(s</i>						23d. Date Mor	e of delive	ry Day Year
7	law requires that the dias been signed by the 2 should be detached	þ	Part II. Other significant conditions	contributing to death bu	ıt not resi	ulting in the ur	nderlying (cause giver	in Part I.						e cause of death?
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lo noi	To the Hospital or Attending Physician: To the Finares after death To the Funeral Director: After this certification the Funeral director; completely filled in by the funeral director;		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day		28b. Time of Injury		28c. Injury a Work?		28	Bd. Describe f				,
DIVISION	s after de s after de al Directo ad in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine		ry - At ho . (Specify	ome, farm, stre	eet, factor	y, office		28	3f. Location (S City or Tox			or or Rural	Route Number,
	To the Hospital or within 24 hours affe To the Funeral Dircompletely filled in	edicai	29a. Certifier 1. Certifying I (Check only one) 2 Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examina	wledge, death tion and/or inv	occurred restigation	at the time	, date and nion, death	place, ar	d due to the	cause(s) date and	and mar place, a	nner as sta ind due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Pierra		MiD		c. License i	number			29d. Da	te signed	(Month, E	Day, Year)
	11		Mtpa	- The same	7			D2766	0			May	15,	200	6
	12+1		30. Name and address of person wh	- 4		123a) (Type, I Rockvill		ike-	#G100). Iv	ckv111	e 1	arvl	and	20852-3109
į	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signa	ture	9	,		9 414	V 4 4 1 1		July J	CALIC	20032-3107
	Registr	ar	MVX 7 1 5000	J. S.	JO.	130000000									

			For State Registrar	State of	Marylan		rtmen tificate			ind M	lental H	giene Reg. No.	2006	155	23
	Physicia		1. Decedent's Name (First, Middle, L	ast)							2. Date of D Month	Day	Yeer	3. Time of D 5:00 A	
	/Medic	al .	Theresa	Ihon	pson		45 015	Tanah as	Location of	1 Dank	MAY	13	2006 ounty of Death		
	Examin	er	4a. Facility Name (If not institution, g 1105 NEW HOPE CIRCLE	ive street and nun	nber)		BALT		Location of	Deam		40. 0	NA		
	Funeral				7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of B	irth Your	9. Birth	place (State or	Foreign
п	Director		220-38-7268	1□M 2 X F	64	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D JULY 10,	1941	NORTH	CAROLINA	
	pug 🖈		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City	Limits
	Maryli f sho	ō	MARYLAND NA		B	ALTIMORE								1 Yes 2	2 🗍 No
	r 28a-	rect	10e. Street and Number				10f. Zip	Code				10g. Citiz	on of What Cou	ntry?	
	th with	by Funeral Director	1105 New Hope Circle				2120	2					USA		
	r dea	ner	11. Marital Status	Armed Fo		S. 13. V	Vas Deced Yes, spec	lent of Hi	spanic Orig n, Mexican,	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	10-	 Race - Ameri Black, White 		
36	rs afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or Da	0	,	I□Yes :	2 ⊠ No	Specify:			5	Specify BLACK	ne .	
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f show ha Medical Exame at must be notified at	ted	15. Decedent's	Education		16a. Deced	lent's Usua	I Occupa	ition	all consti			d of Business/Ir		
215	thin 7.	Completed	(Specify only highest of Elementary/Secondary (0·12)	Colfege (1	-4or 5+)	life. L	OO NOT us	se retired,	luring most)	OF WORK	ng				
2	led wi lygien her th	Con	12	N.	A	JANI	TORIAL		19 Motho	r's Name	(First, Middl		DISCOVERY	MUSEUM	
and	d be findal Head of) Be	17. Father's Name (First, Middle, La JOHN FLOYD	51)					MARY N			o, walour c	umamoj		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting Interest the Intilitied at Once.	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a	and Numbe	r or Rura	al Route Num	ber, City or	Town, State, Zi	Code)	
Z	alth al		VICTORIA HILL DAU	CHIER		1334 N	. FULT	ON AV	ENUE I	BALTI	MORE, MA	RYLAND	21217		
Baltimore,	of He of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from	1 0	lace of Dispo emetery, cren			9)	ī	Date	20c. Loc	ation - City or T	own, State	
<u>Ĕ</u>	Pag ment tant: I		* 4 ☐ Donation 5 ☐ Other (Spec	cify)	MOU	NOIZ TV					, 2006		WNE, MARY	ZLAND	
Ball	Depart Depart Mport Iny in		21. Signature of Funeral Service Lic	ensee							IE FUNEE LITMORE.		S P.A. AND 21217		3
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	/Medical		disease or condition resulting in death)		or as a conseq		0011	1	5	LUI	NU			14 000	CKS
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V	ed sit	iner	cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence of):									
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8760,	cate be executed, physician and the burial-transit	ical		d											
9	rtificat ng phy as th	ed	PECCHAIE.									10000			-
Вох	death certifica e attending pl d for use as t	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live b	come of pregna irth 2 Feta	I death 3	Ectopic pr					23	ld. Date of deliv Month	,	ear .
_	the al	ysic	1 Tes 2 No	4∐Pregn 9∐Unkno	ant at time of down	eath 5	Other (sp	ecify)						,	
P.O.	law requires that the das been signed by the 2 should be detached		Part II. Dther significant conditions	s contributing to de	eath but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Dio	I tobacco us	e contribute to	the cause of de	ath?
ecords,	w requires that been signed is should be det	d by									1)	Yes 2□	No 3 ☐ Pro	bably 4 □Un	iknown
CO	aw rec Is bee 2 shou	Completed									24a. Wa	s an	24b. Were aut	opsy findings av	vailable
Œ	The has age	mo									per 1 □ Yes	formed?	death? 1 ☐ Yes	2 □ No	
Vital	ysician: 1 is certifical director, p	Be	25. Was case referred to medical example?	11. 2.1				0#		of Deatl	(Check only	one)			
of \	this al dir	To	1 ☑ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 🔲		ER/Outpatier			4 🗆 14 0		me 5 Re 28d. Describe		Other (Speci	fy)	
no	After fune	ertiflcation:	1 Natural 5 Pending 2 Accident investigation	(Mon	th, Day Year)	fnjury	м	28c. fnjury Work 1 □ `	(? Yes 2 □ l		200. 0000110	o now injury	3333,133		
Division	Attending r death. ector: Afte by the fune	ifica	3 ☐ Suicide 6 ☐ Could no determin	be 28e. Place	of Injury - At he		eet, factor	y, office			28f. Location	(Street and	Number or Rur	al Route Numbe	er,
ă	s afte	Cert	4 Homicide	Bulla	ng, etc. (Specif	y)					City of 1	OWII, State)			
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	dical	(Check only 2 Medical Ex	Physician: To the aminer: On the b	asis of examina	wledge, death	n occurred vestigation	at the tim	ne, date and pinion, deat	d place, th occur	and due to th	e cause(s) a e, date and p	nd manner as	stated. to the cause(s)	
	thin 2, the I mplet	Med	29b. Signature and title of certifier	and man	ner stated.		290	c. License	number	MD		29d. Date	signed (Month,	Day, Year)	
	With Con) Lath	ion	MD				6134	1 5			/16/		
7	m		30. Name and address of person wi	no completed caus	1 1 1 11 11 11	n 23a) (Type,	Delen						100		100
				AT) MGZL	MC WE	IN BER	7 (F	STER	, 120	OD E	FAYE	77F- ST	BALI	0 mg 2	1202
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	Regist	rar	1 AY 1 7 200	1.7		87									

			1 - For State Registrar	State of M	Maryland / De C	partment of H ertificate of I			giene	6 15524
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea	ath Day Ye	
	/Medic		Michael Deon Tin			T., 6: 7		May 12,	-	4 :15 A ^M
	Examin	ier	4a. Facility Name (If not institution, giv Manorcare	e street and numbe	ar)	4b. City, Town, or Baltin		Death	4c. County of D	peatn
	Funeral		5. Social Security Number 6. S		Age (In yrs. last birthd		If Under 24	Hrs. 8. Date of Birt Min. (Month, Da	th 9.	Birthplace (State or Foreign Country)
	Director		215-04-4734	X M 2□F	35 Yrs	Months Days	Hours	06-25-19		Maryland
	land] }	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f sh	į	MD NA			Baltimore				1 X Yes 2 ☐ No
	or 28g	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath w	ral	37 Terrace Road			21221			USA	
	Hems Hems	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Deceder Armed Force 1 ☐ Yes 2 5	s?	Was Decedent of H If Yes, specify Cuba	ispanic Origin ın, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)		lmerican Indian, Vhite, etc.
920	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	_	1☐ Yes 2☐XNo	Specify:		Specify:	.ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Madical Exambhar rual be notified at	Completed	15. Decedent's E (Specify only highest gra			cedent's Usual Occup- ive kind of work done of		f working	16b. Kind of Busine	
121	vithin ne. han "	m p	Elementary/Secondary (0-12)	College (1-4c	- Inf	 DO NOT use retired Never Worke 	1)		NA	
9	filed v Hygie other t		17. Father's Name (First, Middle, Last,)		TREVEL HOLIK		Name (First, Middle,		
lan	fental rked c	To Be	James D. Bishop					Chery	1 Allen	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Exampler rotal be rotified at		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Street	and Number o	or Rural Route Numbe	er, City or Town, Stat	e, Zip Code)
	1 and Health Iem 27 Sther tra		Gloria Hunter/ Aunt			24 Limond Pla	ace Balt:			
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		te cemetery, o	sposition (Name of trematory or other place	· !	Date	20c. Location - City	
Ħ	permit. Page Department of Important: If any injury or once.		 4 □Donation 5 □ Other (Specif 21. Signature of Funeral Service Licer 		Trinity C	emetery 22. Name and Addres		5-17-06	Dundalk, MD)
Ba	Depar Impo any ir		Sumerla	yours				e 638 N. Gil	mor Street B	Salto, MD 21217
	5		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the death. Do not	enter the mode of dyin	g, such as car	rdiac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Preur	monia					Onset and Death
	/Medical Examiner		resulting in dealth)		as a consequence of):	A C	010	-0 S	01-041	
		Jer.	Sequentially list conditions, if any, leading to immediate	p. 140que (or	as a consequence of):	munol	Low	may sy	nanva	1
H	nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c			`			
8760,	death certificate be executed e attending physician and od for use as the burial-transit	S EX	resulting in death) Last	Due to (or a	as a consequence of):					
687	physi s the b	dical	•	d						
X	death certific attending pl	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		2 🗆 🗆			23d. Date of	delivery
Ω.	e death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	3 Ectopic pregnancy 5 Other (specify)			Month	Day Year
P.0	The law requires that the de ste has been signed by the a page 2 should be detached		9 ☐ Unknown Part II. Other significant conditions of	contributing to death	hut not resulting in th	a underlying cause give	en in Part I	23e Did to	hacco use contribut	e to the cause of death?
ecords,	uires t signe Id be	d by	,	, , , , , , , , , , , , , , , , , , ,	. out is a saming in the	o arraony ing odoso givi	J			Probably Unknown
00	s been si	Completed						24a. Was		autopsy findings available
	The lav	mo						— autop perfor 1 ☐ Yes	rmed? death	to completion of cause of 1? /es 2 No
Vital	ysician: Th is certificate director, pag	Bec	25. Was case referred to medical examiner?					Death (Check only o	ne)	
of \	hys this al dii	2	1 Yes 2 No	Hospital: 1 ☐ Inpa				ng Home 5 Resid		Specify)
	ing After une	tlon	27. Manner of Death Thatural 5 Pending 2 Accident investigatio	28a. Date of Ir (Month, I	njury 28b. Time Day Year) Injur	y Worl	γατ k? Yes 2.⊟No	280. Describe n	now injury occurred	
Division	Il or Attending after death. Director: After d in by the fune	Certification;	3 Suicide 6 Could not b	e 28e. Place of	Injury - At home, farm, etc. (Specity)	street, factory, office		28f. Location (S City or Tow	Street and Number or	Rural Route Number,
	ital or A rs after ral Direction by	Cert	4 E Homodo	Dulluling,	otc. (Opecity)					
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in h	Medical	29a. Certifier T—Certifying Pt (Check only one)	nysicien: To the be niner: On the basis and manner	st of my knowledge, do s of examination and/o stated.	investigation, in my of	pinion, death o	place, and due to the occurred at the time, o	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To To I	2	29b. Signature and title of certifier	A.N		29c. License			29d. Date signed (Mo	
,			30 Name and address of parson who		f death (Item 23a) (Ty	25 g	いてナ		5-15-	210/21
	8		1 1 1	rdon =	LSVE DO	kumped	CD S	की करि	Celeu B	urry,
	Sta Regist		31. Date filed (Month, Day, Year)	006 32 legi	strar's Signature	porti				· •

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** -RANK 2300 PM WILLIAMSON 2006 MA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Randallstown Baltimore WD Northwest HOSPITAL enter If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours **1**ØM 2□F 21542157 0 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f ahow in than "natural, or items 23e or 28e-f aho Yes 2 No Director MO stimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify White 2 3 ☐ Widowed 4 ☐ Divorced is marked other than "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Golf Course 12 Recreation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be a Frank T. Williamson Hazel Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Heelth and Important: If Item 27 ia m any injury or other traum once. Dorathea Williamson / Wife 3507 Keston Road, Baltimore, MD 21207 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 5/20/2006 4 □ Donation 5 □ Other (Specify) Catonsville, MD 22. Name and Address of Facility
1. Kaufman Funeral Home at Meadowriche Memorial Park, IN.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 Approximate Interval Between Onset and Death and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Immediate Cause (Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and stransit the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the ettending properties of 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the e o 9 Unknown 9 Unknown α. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 Yes 2 💢 No of Vital To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 2 DER/Outpatient 3 □ DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Matural Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a
To the Funeral I
completely filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier H005133° 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. LAWRA HARLY a RD NWHC 5401 OID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

			For State Registrar	State o	f Marylan		artment of H			giene leg. No.200	6 15526			
	Physici	an	1. Decedent's Name (First, Middle Benjamin Lee V						2. Date of Dea Month 5-14-(Day Y	3. Time of Death 3P			
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nut	m <i>ber</i>)		4b. City, Town, or	Location of Dea		4c. County of				
	LAGIIIII	6.	Mariner Health	& Rehab			Glen Bur	nie		Anne A	rundel			
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day		Birthplace (State or Foreign Country)			
	Director		209-14-2820 Usual Residence of Decedent	1 A 1111 2 0 1	7.9	Yrs.			12-9-	1926	PA			
	ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits			
	Mary I-f sh	tor	MD Howai	rd	E1k	ridge					1 ☐ Yes 2 🙀 No			
	or 28s	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?			
	23a ust b	rai	8010 Paul Mart				210			US				
	tams	Funeral	11. Marital Status	Armed Fo	edent Ever in U	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (: n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Hace - Black,	American Indian, White, etc.			
36	rs aft	by F	1 ☐ Never Married 2 AMar 3 ☐ Widowed 4 ☐ Divorced	If Yas, Gir	ve		1 ☐ Yes 2 No	Specify:		Specify:	Black			
9	I within 72 hours after death with the Maryland jiale. I than "natural", or Itams 23a or 28a-f show The Medical Evanination maliked at		15. Deceder	nt's Education		16a. Dece	dent's Usual Occupa	ation	orking	16b. Kind of Busin	ness/Industry			
215	within 7 ene. than "n	Completed	(Specify only nigne Elementary/Secondary (0-12)	college (1-4or 5+)		kind of work done of DO NOT use retired		Jiking	US A	15mx7			
7	filed wi Hygien other th	S	12. Father's Name (First, Middle,	(4)		IIai	sportatio		ıme (First, Middle,		II my			
Maryland 21215-0036	d ta b	ТоВе	Greene Williams	,				unk	ine (First, Middle,	warden Sumanie,				
lan	and and Is IT		19a. Informant's Name/Relations				ng Address (Street a							
	Health tem 27 other tr		Richard William	ns Son			Paul Mar	tin Dr.	, Elkrids	ge, MD 2 20c. Location - Ci	21075			
Baltimore,	Pages 1 and Heat of Heat of Heat Int. If item Irry or otha		20a. Method of Disposition Y☐Burial 2 ☐ Cremation			comptoni cra	natory or other place le Vetera letery	ns May						
<u>==</u>	it. Pa rtmen rtant: njury		* 4 □ Donation 5 □ Other (\$21. Sign of real Funeral Service		10-		ietery 2. Name and Addres		1		100000000000000000000000000000000000000			
Ba	permit. Pages. Department of Important: If ite any injury or of		k. Gregory	Fink	MO1148	3 2	ink Funer 26 Crain	Hwy S,						
	Physician /Medical Examiner	er	23a. Part Enter the disease of shock or heart failure List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a	or as a consec	quence of):	وبع	g, 300 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i a 3 i						
,0928	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the bunat-transit	dicai Examine	cause. Enter Underlying Cause (Unisease or highly that initiated events resulting in death) Last	c Due to d.	(or as a consec	quence of):								
P.O. Box 6	that the death certific.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregn birth 2 Feta nant at time of d	al death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month				
	quires that in signed build be det	by	Part II. Other significant condit	ions contributing to contribut		sulting in the u	inderlying cause give	en in Part I.			ute to the cause of death? Probably 4 @Unknown			
Il Records,	The ate h page	Completed	Dembili	is We	Λ					sy prio	ore autopsy findings available or to completion of cause of ath?			
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Magnital			Oth	25	eath (Check only o					
of Vital	Physician: r this certificatal director, a	To.	1 Yes 2 No	28a. Date	Inpatient 2	ER/Outpatie		4 V Hausing	Home 5 ☐ Resid	lence 6 Other				
u _o	ling After fune	tion	1 SNatural 5 ☐ Pend	/A 40×	nth, Day Year)	Injury	Worl	(? Yes 2 □ No		,,				
Division	or Attending after death. Diractor: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At h ling, etc. <i>(Speci</i>	nome, farm, st ify)	reet, factory, office		28f. Location (S City or Tow	Street and Number In, State)	or Rural Route Number,			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai Ce		ing Physician: To th I Exeminer: On the to and mar										
	ro the vithin o the	Me	29b. Signature and title of certifi	er			29c. Licens			29d. Date signed (
	->-0	l i	> Magos	Zower MA) —		D-(15204		May 16,	2006			
			30. Name and address of person DR. OCH	n who completed cau		m 23a) (Type	Print) 3 25	HOUPE EN BN	RNIE (ND ZIE	2006 1TE 208			
	St Regist	ate rar	31. Date filed (Month, Day, Yea MAY 1 7 2	006	Registrar's Sign	ature	200							

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of N	Maryland	•	artment of H		nd Mental H	ygiene Reg. No.		15507
			Registrar 1. Decedent's Name (First, Middle,	Last)			tinicate or t	Jean	2. Date of I		CULID	3. Time of Death
П	Physici			ngton					Month May	Day	006 Year	11:37P ^M
	/Medic Examin		4a. Facility Name (If not institution,		er)		4b. City, Town, or	Location of I			County of Deat	
ı	ZAGIIIII	Ŭ.	7981 Eastern A	venue. #30	1		Silver	Sprin	ıg	1	Montgom	erv
	Funeral		5. Social Security Number		Age (In yrs. la	•	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of E		9. Birt	hplace (State or Foreign
	Director		413-92-8666	TXIM 2 L	51	Yrs.			March	11,	1955 Ten	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Maryl 1 • hg	ō	Tennessee Shelb	**	Memp	oh i a						1 XYes 2 No
	r 28a	Director	Tennessee Shelb	У	riemp	71115	10f. Zip Code			10g. Citi	zen of What Co	lountry?
	h with		908 Castlewood				38109			Unit	ted Sta	tes
	SE SE	Funeral	11. Marital Status	12. Was Decede Armed Force		. 13.	Was Decedent of Hi	ispanic Origin	n? (Specify Yes or I Puerto Rican, etc.)	10-	14. Race - Ame Black, Whit	
9	or It	by Fu	1 X Never Married 2 ☐ Marrie	ed 1 X Yes 2 [If Yes, Give	^{□ №} 1973		1 □ Yes 2 🗓 No		, , , , , , , , , , , , , , , , , , , ,		Specify:	0, 010.
ğ	within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-f ehow the Mudical Exatt art must be notified at	d b	3 □ Widowed 4 □ Divorced	Year or Date	s: 1980		dent's Usual Occupa	-ti		105 10	E	Black
7	in 72	Completed	15. Decedent' (Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	durina most o	of working	160. KI	nd of Business	industry
212	iene.	E	Elementary/Secondary (0-12)	College (1-4d	or 5+)	F1	ight Atte	ndant		Cor	nmercia	l Airlines
פ	a filed other	BeC	17. Father's Name (First, Middle, L	ast)					s Name (First, Midd			11111111100
<u>a</u>	ould be Mental arked o	To E	Booker T. Wash	ington				Lou	ise Myers	3		
ar	2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. In marked other them "naturel", or items 23a or 28a-1 show aumatic event, it a Medical Exam our meater event.		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street a	and Number	or Rural Route Nurr	ber, City o	Town, State, 2	Zip Code)
Baltimore, Maryland 21215-0036	es 1 and 2 should b of Health and Ment fitem 27 le markec r other traumatic e		George Washing	ton/Brothe				lls Ci	rcle, Con	-		
ore	ges 1 t of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from Sta	Cer	metery, crei	osition (Name of matory or other plac nessee	<i>ө)</i> Н	Date lay 18,	20c. Lo	cation - City or	Town, State
Ħ	t. Partmen		4 Donation 5 Other (Sp	A	Vet	aranc	Comotory		006	Memp	phis, T	ennessee uneral Home/
Ba	permit. Pages 1 Department of H Important: If ite eny injury or ott		21. Signati Funeral Service L	19500	1400	I R	ethecda-C	heww (hage Ind	750	7 11100	onsin Avenue
		-	23a. Part1. Enter the disease, or	complications that cause	MUU sed the death	OUD B	ethesda,	Maryla	100 20814	+-350		Approximate
	Serve.		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	n line.			-				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		oscler		Cardiovas	cular	Disease			Years
	Examiner					3.100 0.7.						
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseque	silve ut).						- Spirit
	ecuter Ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					<u>-</u>			
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ai E	Tooling III down, such	Due to (or	as a conseque	ence or):						
687	phys s the	dlcai		d							_	
Box	eath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							23d. Date of del	iverv
	death e atte	icla	in the past 12 months?	4□Pregnant	2 ☐ Fetal of at time of dea		Ectopic pregnancy Other (specify)				Month	Day Year
o.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknowr	1							
	6 50	by P	Part II. Other significant condition	ns contributing to death	n but not result	ting in the u	nderlying cause give	n in Part I.	23e. Dio	tobacco u	se contribute to	the cause of death?
or G	w require been si should b	te d							_ 1	Yes 2[⊒No 3⊟Pr	obabły 4 Munknown
Vital Records,	law law las bu	Completed							24a. Wa	opsy	prior to o	topsy findings available completion of cause of
<u> </u>		S								formed? 2.\X\No	death?	2□ No
\frac{1}{2}	nysician: Th nis certificate i director, pag	Be	25. Was case referred to medical examiner?	Hospital:		_	t all Doa Othe		f Death (Check only		**	Brother's
	<u>a</u> = <u>a</u>	. To	1 X Yes 2 No 27. Manner of Death	28a. Date of I	njury 2	R/Outpatier 28b. Time o	I 3 DOA	4 Nursi	ing Home 5 ☐ Re 28d. Describe	sidence 6 how injury	Other (Spectocolor)	Residence
0	th.: After	ફ	1 Natural 5 Pending 2 Accident investig	(Month, i	Day Year)	Injury	f 28c. Injury Work	(? Yes 2 □ No	,			
Division of	Attendi ar death. ector: A by the fu	HCg	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	and 28e. Place of	Injury - At hometric. (Specify)	ne, farm, str	eet, factory, office		28f. Location	(Street and	Number or Ru	ral Route Number,
Ξ	tal or	Certification:	T I I I I I I I I I I I I I I I I I I I	building,	olc. (Specify)				Only of 1	Own, State)		
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1X Certifying (Check only one)	Physician: To the be examiner: On the basis and manner	of examination	ledge, deat on and/or in	h occurred at the tim vestigation, in my op	ne, date and pointon, death	place, and due to th occurred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner	111	10 8	29c. License	number		29d. Date	e signed (Monti	n, Day, Year)
			> Patricia	10moko	May,	md	D519	916		Мат	16, 20	06
	2X1		30. Name and address of person v	no completed cause of	f deate (Item 2	23a) (Type,		, 10		nay	10, 20	0.0
	,5,		Patricia Tomsko	Nay, M.D.	1111	9 Roc	kville Pi	ke, #G	-100, Roc	kvil1	e, Mary	1and 20852
	Sta		31. Date filed (Month, Day, Year)	32. Regi	strar's Signatu	THE STATE OF THE S	E .					
	Registr	ai	MAY 1 7 201	JO PERSON								

		1	For State Registrar	State of Maryla		artment of H rtificate of L			giene Reg. No.	006	15528
14	A		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic	al	Joan Healy Wroten			,		MF		2006	
) s v 	Examin		4a. Facility Name (If not institution, give s Saint Joseph M	treet and number) edical Cen	iter	4b. City, Town, or	Tow	son	4c. Cou		imore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours M		th ly, Ye <i>ar)</i>	9. Birth Cou	place (State or Foreign ntry)
E.	Director		217-24-3960	79	Yrs.			Oct 14	, 1926	Mary	land
	and	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	Maryl f sho	ō	MD Baltimon	T.	owson						1 ☐ Yes 2√∑ No
	the r 28a	Director	10e. Street and Number		0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	h with		821 Stagshead Roa	d		21286			USA		
	deat	Funeral		2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	(Specify Yes or No lerto Rican, etc.))- 14. F	Race - Ameri Black, White	
9	tiled within 72 hours atter death with the Maryland Hygiene. other than "natural", or Items 23s or 28s-f show sett, the Mscheal Exempler must be motified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🎛 No If Yes, Give		1 ☐ Yes 2 No				city:	
Ö	hours tural',		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind o	W] Business/Ir	nite ndustry
7	in 72	olete	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	during most of t	working			,
Maryland 21215-0036	iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) one	Ноч	ısewife			Own H	ome	
ק	e filec of the vent,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle	, Maiden Sun	name)	
<u>lar</u>	Menta	2	J. Kenneth Healy					E. Gau			
an.	and and le ma		19a. Informant's Name/Relationship (Ty			ng Address (Street				wn, State, Zi	p Code)
<u>2</u>	l and lealth m 27		Jack Wroten/spous	The second secon	A COLUMN TO SERVICE AND ADDRESS OF THE PARTY	Stagshead	Rd. To	Date Date		on - City or T	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Its Madical Extending must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R		cemetery, cre	matory or other place	(e)				
Ħ H	rtmer rtmer rtent: njury		4 Donation 5 Other (Specify) 21, Signature of Funeral Service License		2	2. Name and Addres	ss of Facility				
Ba	perm Depa Impo any i			Nade Direct	or S	tate Anat	omy Boa	rd 655 W	. Balt:	imore	Street
	2		23a. Part1. Enter the disease, or compli	cations that caused the de		altimore, ter the mode of dyin		diac or respiratory a	ırrest,		Approximate Interval Between
	Dhysisian		shock, or heart failure. List only or Immediate Cause (Final		ie ean	n t mwvmma	STELLISZ.				Onset and Death
-	Physician /Medical		disease or condition resulting in death)	Due to (or as a cons		D T ON A OF-F	1111				MEEUD
	Examiner		Constitution that constitutions	CORONARY	ARTER	Y DISEAS	E .				YEARS
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
4	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	and and all						
8760,	ate be executed hysician and the burial-transit	al E)	Tooland and stand and stan	Due to (or as a cons	equence or).						
387	death certificate be executed e attending physician and of for use as the burial-transit	dical		1.							
9 x	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre					23d.	Date of deli-	very
Вох	death a atter	clar	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time of		□Ectopic pregnancy □ Other (specify)	<u>'</u>			Month	Day Year
o.	that the de ed by the detached	hys	9 Unknown	9□ Unknown				-			
S, D	S C 0	by P	Part II. Other significant conditions con		resulting in the	underlying cause giv	en in Part I.		V		the cause of death?
ord	w require been sig	ted	METASTATIC RENA	L CARCINOMA				- 10	Yes 2 N	o 3 ☐ Pro	bably 4 Unknown
ecc	aw Is t	ple						_ 24a. Was	ppsy	prior to c	topsy lindings available ompletion of cause of
= E	T ate	Completed						1 ☐ Yes	ormed? 2 No	death?	3/240
of Vital Records	Physicien: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth acidos Oth	or	Death Check only			
of	S S	7.	1 ☐ Yes 2 1 No 27. Manner ol Death	1 A atient 2	PER/Outpatie 28b. Time	SIL SU DOA	4 11 14 11 511	ng Home 5 ☐ Res 28d. Describe			uty)
	ing Vfter	ton	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) Injury		rk? Yes 2∐No				
Division	of or Attending after death. I Director: After din by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - A	t home, larm, s	treet, factory, office			(Street and Nown, State)	umber or Ru	ral Route Number,
á	el or safter	Certification:	4 Homicide	building, etc. (Spe	ecily)			Only of 70	own, ciato)		
	ne Hospitel or Attendi n 24 hours after death ne Funerel Director: A	Medical	29a. Certifier 12 certifying Phy (Check only one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea ination and/or i	ith occurred at the til nvestigation, in my o	me, date and popinion, death o	lace, and due to the occurred at the time	e cause(s) and , date and pla	manner as ce, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	1 2		29c. Licens	se number		29d. Date si	gned (Month	n. Dey, Year)
	F ≯ F ŏ			lelar, M.	D -	מממים.	17695		May	11, 2	-006
			30. Name and address of person who c				a 1 10° 0′ 100°		<i>U</i>		
	0		ABDALLAH J. HEI	OU M D 7	601_0S		VE TOW	SON, MA	RYLANI	212	Ø4
	St	ate	31. Date liled (Month, Day, Year)	37. Registrar's Si	gnature						
*	Regist	rar	MAY 1 7 2006	District	J. Dal	3482					

			T = For State Registrar	State of Ma	ryland /			of Health of Death		_	giene	006	15529
	1 Kg 1	7	1. Decedent's Name (First, Middle, Las	it)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Clara		т.		Y	oung		MAY	12	2006	2:30 AM
	Examir		4a. Facility Name (If not institution, give	street and number)				wn, or Location	of Death	/	4c. Cou	nty of Death	-
42				TAL OF B				LTIM				,	
	Funeral Director		5. Social Security Number 6. Security Number 220–12–9675 Usual Residence of Decedent	UN OUL	(In yrs. last t	Yrs.	If Under 1 Y Months D	ays Hours	Min.	8. Date of Birt (Month, Da 08 1	y, Year)_	Coun	lace (State or Foreign htry) MD
9	land		10a. State 10b. County		10c. City, To	own or Loc	cation	-				1	Od. Inside City Limits
Young	ith the Marylar or 28a-f show	tor	MD NA		Balt	imoı	ro						1 🛱 Yes 2 🗆 No
20	r 28a	Director	10e. Street and Number		Dare	, <u>1</u> 11101	10f. Zip Co	ode			10g. Citizen	of What Coun	ntry?
	h wit	a D	3805 Granada Av	re				21207	•		1	U.S.A	•
2	after dea or iteme	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent	t of Hispanic Or Cuban, Mexica	rigin? (Spe	cify Yes or No-	14. F	lace - Americ Black, White,	
LARA 036	rurs after death with the Maryla al; or Iteme 23a or 28a-f sho Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:	0		☐ Yes 🏖			,,	-		ack
2-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	Sa. Deced	ent's Usual O	occupation done during mos retired)	st of workin	ng	16b. Kind of	Business/Ind	dustry
2121		E G	Elementary/Secondary (0-12)	College (1-4or 5+	-)		omest:				D:	rivat	
d 2	filed Hygid Sther ant,	ပို	10th grade 17. Father's Name (First, Middle, Last)	na		טע	omest.		er's Name	(First, Middle,			е
prownaryland	d be antal ked o	To Be								I. Gra		,	
Z Z	should nd Men marke	F	Warren Parran 19a. Informant's Name/Relationship (7)	ype, Print)	19	9b. Mailing	g Address (Si	treet and Numb				vn. State. Zip	Code)
Z Z	s 1 and 2 should t Health and Mer Itam 27 is marke other traumatic		Sylvia Tapp-Nie	ece				vale R					
fatical from altimore, Maryland	ges 1 and 2 it of Health at tite 27 is or other tra		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of	of		ate		n - City or To	
73 8	Page: ient o int: if ry or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State			-		5/1	9 /06	Dand	allat.	own, Md
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	S88	KING	22.	Name and A	Address of Facility F/H We	ity _	8700	Kanda	allsu	OWII, MG
m	permi Depa Impo any ir		Switte !	K. Jmes		4.	arcn 1 300 Wa	r/н we abash	st Ave.	Balt:	imore	. Md	21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to	he death. De								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPSI									Onset and Death
	/Medical		resulting in death)	Due to (or as a		e of):							1 aag
	Examiner		Sequentially list conditions	b. SEVERF	E Ar	YEN	11A						lday
	ב ס	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a		e of):							0
illy.	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c		()							
90,	be ex cian	E		Due to (or as a	consequenc	e or):							
8760	ta EE	dical	•	d									
9 ×	leath certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, outcome or	f pregnancy						201	2-1	
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2	Fetal dea		Ectopic pregn Other (specif					Date of delive Month	ry Day Year
o.	by the detached	ysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		00	Other (Speed)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
٥	es that igned b be deta	by P	Part II. Other significant conditions or	ontributing to death but	not resulting	j in the un	derlying caus	e given in Part I	l.	23e. Did to	bacco use co	ontribute to th	e cause of death?
rds	w requires been sign	d be	(BRONARY AF	2TFRY	DISE	ASI	<u> </u>			1 🗆 Y	es 2 No	3 ☐ Prob	ably 4 🖫 thknown
8	s bee	ompieted	HYPERTENS	JON						24a. Was a	an 241	o. Were autop	osy findings available
R	Attending Physicien: The law requires that the death certific reath. •ctor: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as!	E								autop perfor	med?	death?	osy findings available inpletion of cause of 2 M No
ital	sicien: Th certificate rector, pag	Se C	25. Was case referred to medical		-			26. Place	e of Death	1 Yes	-	1 🗌 Yes	2 1 NO
>	nysica lis ce direc	To B	examiner?	Hospital: 1 Inpatient	t 2 ER/C	Dutpatient	3□ DOA	Cther: 4 ☐ Nu				ther (Specify	')
0	ding Ph. h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b	. Time of	28c.	Injury at Work?		8d. Describe h			-
.0	ttendir death. ctor: Af y the fu	atic	2 Accident investigation			,,	М	1 Yes 2	No				
Division of Vital Records, P.O.	i or Attuater de Directe	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, stre	et, factory, of	fice	2	8f. Location (S City or Tow	treet and Nur n, State)	mber or Rural	Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phy	ysician: To the best of uner: On the basis of e and manner state	examination a	ge, death and/or inve	occurred at the estigation, in	he time, date ar my opinion, dea	nd place, as ath occurre	nd due to the o	ause(s) and date and place	manner as sta e, and due to	ated. the cause(s)
_	within 2 To the comple	Me	29b. Signature and title of certifier				29c. Li	cense number		2	29d. Date sign	ned (Month, L	Day, Year)
	. 21 0		1/hatter	MOR MI	>		R	ES -C	000		MAY	12.	2006
			30. Name and address of person who o	completed cause of dea	ath (Item 23a	ı) (Type, P				A	- /	, ,	2006
_	4		VIVEK KUM	AR M	D _	اسارد	ai H	ospita	360	& Ba	ltimo	re	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 7 20	32. pegistrar	's Signature	Lon	salle)	1		V			

			1 - For Registrar	State of	Maryland / D	epartmer Certificat			nd Me		- 2	006	155	530
			Hegistrar Decedent's Name (First, Middle, L.	ast)	^	Cortinoat	0 0/ 2	Jean	2	. Date of Dea	Reg. No.∈⊸ ath		3. Time of 0	Death
	Physici		GENA	1.	As	UNCI	01			Month A	Day	Z W	0908	М
	/Medio Examin		4a. Facility Name (If not institution, g	ive street and numb	oer)	4b. City,	Town, or	Location of	Death	1	4c. Co	unty of Deat		
			Shady Grove Adve				kvil						tgomery	
	Funeral		,	Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs. last birt	Yrs. If Under	1 Year Days	If Under 24 Hours	Min.	Date of Birtl (Month, Day	h v. Year)	Co	hplace (State or untry)	
	Director		213-96-7187 Usual Residence of Decedent		41	113.			J	uly 18	, 196	4 Sou	th Kore	a
	hours after death with the Maryland lurei', or itsme 23a or 28a-f ehow al Examinar mant be politised at		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City	y Limits
	Maria si	tor	Maryland Montgor	nery	Clarks	sburg							1 🗆 Yes	2 🔀 No
	or 28	Funeral Director	10e. Street and Number			10f. Zig	Code				10g. Citizen	of What Co	untry?	
	ath w	rai	22800 Timber C	-		208						th Ko		
	its m	une	11. Marital Status	12. Was Deced	es?	13. Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origii n, Mexican, I	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		Race - Ame Black, White		
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1 ☐ Yes	26 No	Specify:			Sp	ecity:Asi	an	
215-0036	172 hours after death with the Marylar "naturel", or iteme 23a or 28a-f show idical Examirer must be notified at	ted	15. Decedent's		16a.	Decedent's Usu	al Occupa	ation			16b. Kind	of Business/	Industry	
215	d within 72 ho piene. ir then "natur ir e Medical	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4	or 5+)	(Give kind of wo life. DO NOT u	se retired	iunng most d ')	of working					
2	filed wi Hygien other th	Cou		2		Homema	ker					Own H	ome	
and M	9 7 2	Be	17. Father's Name (First, Middle, Las Ho Kyun In	st)					s Name (Soor	First, Middle,	Maiden Sui	mame)		
Maryland	es 1 and 2 should be filed of Health and Mental Hygi I fitem 27 is marked other r other traumatic svent, I	10	19a. Informant's Name/Relationship	(Type Print)	10h	. Mailing Address	(Street o				City or To	um Stata	Tin Code)	
S S	id 2 should lith and 27 is m. trsum.		Michael E. Asuno											
ē,	t and Health tsm 27		20a. Method of Disposition	cion/ nus	20b. Place of	2800 Tim Disposition (Na	ne of		Lane			ion - City or		
Ë	Pages nent of unt: if It ury or o		1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			y, crematory or d Heaven Ce			ay 5		Silvo	m Com	ing, Ma:	wilon
altimore,	permil. Pages Depertment of I Important: If It any injury or o		21. Signavire of Funeral Service Lic			Frances	nd Applares	es in in	ns Fu	neral	Home	Inc.		
m	88E # 8		(mobile)	Lole		500 Uni	vers	ity Bl	lvd,	W, Sil	ver S	pring	, MD 209	901
П			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau y one cause on eac	ised the death. Do not line.	not enter the mod	le of dying	g, such as ca	ardiac or I	espiratory ar	rest,		Approximate Interval Betw	reen
	Physician		Immediate Cause (Final disease or condition	a MetA	static	645T	RIC	Car	16	R			Onset and D	
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of	of):								
		B.	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of	of):								
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									ļ		
ó	te be executed ysicien and le burial-transit		resulting in death) Last	Due to (or	as a consequence of	of):								
3760,		ical		d										
39	artifica ing ph e as ti	Med	IF FEMALE:											
Box	death certifica e ettending ph id for use as ti	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	me of pregnancy h 2 Fetal death	3 □Ectopic p					23d.	. Date of dea Month	,	ear
o.		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9☐Unknow	nt at time of death m	5 Other (sp	pecify)							
م ِ	law requires that the as been signed by th 2 should be detache	y Ph	Part II. Other significant conditions	contributing to dea	th but not resulting in	the underlying o	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of de	eath?
Records,	w requires been sign should be	ed by	Acute REN.	ac fai	lure					1 🗆 Y	es 2 DON	lo 3∏Pr	obably 4 🗍 U	nknown
ပ္သ	aw re	Completed								24a. Was a		4b. Were au	topsy findings a	ıvailable
ř	The ste h page	E O								autop perfor 1 Yes	med?	death?	completion of ca 2 □ No	iuse of
ita	cian: ertific actor,	Be (25. Was case referred to medical examiner?						of Death (Check only o				
5	physician: The lav this certificete has al director, page 2	မှု	1 ☐ Yes 2 ☑ No	-	patient 2 ER/Out			4 Nurs		5 Resid			cify)	
Division of Vital	ng f	lon	27. Manner of Death 1 Natural 5 ☐ Pending			ime of a njury M	28c. Injury Work	rat c? Yes 2.∐No		d. Describe h	ow injury oc	curred		
S	Mtsndi death. ctor: A y the fu	licat	2 Accident investigati 3 Suicide 6 Could not determine	be One Diego	f Injury - At home, fai			193 2 10		f. Location (S	treet and N	umber or Ru	ral Route Numb	ber
2		Certification;	4 Homicide	building	, etc. (Specify)		,,			City or Tow				
	Hospit 4 hour Funers tely fille	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physicien: To the bas aminer: On the bas and manne	est of my knowledge is of examination and r stated.	, death occurred d/or investigation	at the tim	e, date and pinion, death	place, an occurred	d due to the d at the time, d	ause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)	
1	To the within 2 To the complet	Me	29b. Signature and title of certifier	sall m	1>	'7	c. License	2.21	7		21	,	n, Dey, Year)	
	1		30. Name and address of person wh		of death (Item 23a) (Type, Print)		<u>_</u>		, 1	, 77	' 6	,	
	•				222 fie	derick	にし	417	213	64H	hous	July 1	ND 20	277
	Sta Registi		31. Date filed (Month, Day, Year)	2006 32. Reg	gistrar's Signature	Parte						1		
DH	MH 17 Rev 1/2	-	erent U Z	2000	Ester 18.	KARRE								

				tate of Maryland	/ Depa		lealth and I	Mental Hyg	•	6 1553
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Elizabeth Lorra 4a. Facility Name (If not institution, give stree			4b. City, Town, o	r Location of Death		Day Yeer 29, 2006	8:30a ^M
	Funeral Director		1084 River Bay R 5. Social Security Number 218–28–4722 Usual Residence of Decedent	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	nnapolis If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep. 19	Year) 9. Bi	ne Arundel hthplace (State or Foreign ountry) MD
poelsoe M. oc.	Sa-f show	ector	10a. State 10b. County MD Anne Arund	loc. City, To	own or Loc	Annapo	lis			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
die die	23a or 2	ai Dire	10e. Street and Number 1084 River Bay Road			10f. Zip Code	21409	10	og. Citizen ol Whal C US	-
17215-0036 within 72 hours ofter death with the Maryland	ital Hygiene. event, the Medical Examiner mast be inclined at	by Funeral Director	1 ☐ Never Married 2 Married	Vas Decedent Ever in U.S. Amed Forces? □ Yes 2 2 No I Yes, Give ∕ear or Dates:		Vas Decedeni of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Am Black, Whi	
OSOU-CIZIZ	ene. than "netur	Completed	15. Decedent's Education (Specify only highest grade contemporary) Elementary/Secondary (0-12)	n 10 npleted) College (1-4or 5+)	(Give I life. E	ent's Usual Occup kind of work done OO NOT use retired	during most of work	sing	16b. Kind of Business	,
Maryland Z	d other	To Be Co	17. Father's Name (First, Middle, Last) Walter McKenna		11	Onemaker	18. Mother's Nam	e (First, Middle, N		<u>lle</u>
	. a ≘ a		19a. Informant's Name/Relationship (Type, F Oliver Richard Bell/	Husband	108	4 River	Bay Road,	Annapol	-	1409
baitimore,	Department of the importent: if its eny injury or ot once.		20a. Method of Disposition 1	val from State	ro Cro Ba:	ition (Name of latory or other place ematory Name and Address **Tranco &	May Sons, P.	2006 A. Sever	Baltimore, na Park Fi	MD neral Home
Wedic Examin Applications and Provided	Medical xaminer liansi la prize la priz	edicai Examiner	23 art1. The disease, or complication hock, wheart failure. List only one cample and disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d		ce of):	r the mode of dyin	g, such as cardiac	or respiratory arre	la Palk, I	Approximate Interval Between
death cert		by Physician/Med	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal dea Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
The law requires that the	been signed b should be deta		Part II. Other significant conditions contribu	ling to death but not resulting	g in the und	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
_	G (7	e Completed	Uypu Schule 18 Chule 25. Was case referred to medical	inc Cerelia	mjá	patu	26. Place of Deat	24a. Was an autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Lor Attending Physician:	er death. rector: After this ce by the funeral dire	Certification: To B	2 Accident investigation	ia. Date of Injury (Month, Day Year)	o. Time of Injury		al ? /es 2 \(\text{No} \)	28d. Describe how		
5 8	Dir		4 Homicide determined 20 29a. Certifier 1 Certifying Physician	e. Place of Injury - Al home, building, etc. (Specify) 1: To the best of my knowled on the basis of examination.	ige, death	Occurred at the tim	e date and place	City or Town,	use(s) and manner as	stated
To the Hospital	within 24 To the F complete	Medical	29b. Signature and little of certifier	On the basis of examination and manner stated.		29c. License	number 2831	1 290	d. Date signed (Monta	h, Day, Year)
	Sta Registr		30. Name and ad hess of parson who complete the complete that the complete the complete that the compl	36. Registrar's Signature		illo De	lowse h	Hamy 1	thropolic	s, mD 21401

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30, 1:06 PM 2006 Burke April Mary Elizabeth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Neme (If not institution, give street end number) Examiner ROCKVILLE If Under 24 Hrs. 8, 1 SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 □ M 250 F 70 March 2,1936 Washington, DC Director 578-50-1465 Usual Residence of Decedent daath with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any lijury opetiper traumatic event, the Medical Examiner must be nuttilled at any lijury opetiper. 1 ☐ Yes 2 X No Directo Maryland Montgomery Montgomery Village 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 19310 Club House Road 20886 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔼 No If Yes, Give Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ring most of working te. DO NOT use retired, Personnel Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Management Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Trunnell Joseph A. Burke, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Carter Road, Rockville, Maryland 20852 Dorothy O'Donnell/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 5/4/2006 Silver Spring, MD 22. Name and Address of Facility DeVol Funeral Home of Funeral Service License 21. Signatu - 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner attending physician and for use as the bunal-transit The law raquiras that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 🗓 Unknown 1 Tyes 2 No ð 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 1 No 1 ☐ Yes this certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 DEFVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) D0057455

Sunil Saxena, M.D., 9901 Medical Center Dr., Rockville, Maryland 20850

32 Registrar's Signature

State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

2006

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Ba	perm	der de
- 現代		/sic ledi ami
DIVISION OF VITAL RECORDS, P.O. Box 68760,	Hospital or Attending Physician: The law requires that the death certificate be executed thous after death	uneral Director: After this certificate has been signed by the attending physicien and

		For State Registrar	State	of Maryla		artment of H			giene Reg. No. 20	0.6	15533
Physic		Decedent's Name (First, Middential)	le, Last) EMMA	BRUNN	IFR			2. Date of Dea Month APRIL	ath Day	Year 2006	3. Time of Death 3:53 P M
/Med Exami		4a. Facility Name (If not institutio			· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	Location of Dea		4c. County		3.33 1
		WASHINGTON	ADVENTIST	HOSPIT	CAL	TAKO	MA PARK		MON	TGOM	ERY
Funeral Director		5. Social Security Number 579-24-2641	6. Sex 1 ☐ M 2X F	7. Age (In yrs 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year) 0, 1924	g. Birthp Coun WASI	lace (State or Foreign try) H. D.C.
and w		Usual Residence of Decedent 10a. State 10b. County	,	10c C	ity, Town or Lo	ocation				1	Od. Inside City Limits
Maryli f sho	5		GEORGES	100.0		HYATTSVIL	TC				1 X Yes 2 □ No
r 28a-	Director	10e. Street and Number	GEORGED			10f. Zip Code	LE		10g. Citizen of V	What Coun	try?
th with		5805 QUEEN	S CHAPEL	RD.		2	0782		U.S	.A.	
and 21215-0036 be filed within 72 hours after death with the Maryland hall Hygiene. d other than "natural", or items 23a or 28a-1 show event, if a Medical Evaminar must be rodified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 ☐ Yes	2 ∕∏No ve		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 【XNo		Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, o	etc.
215-003 thin 72 hours. e. sn "natural", Medical Eval	ted		it's Education		16a. Dece	dent's Usual Occupa	ation	,.	16b. Kind of Bu		
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aryland 212' should be filed within and Mental Hygiene. marked other than tumatic event, tra M	Be C	EARL	•	NNEDY			18. Mother's Na	me (First, Middle,		,	
2 should and Me	2	19a. Informant's Name/Relations		MMEDI	19b. Mailir	ng Address (Street a	and Number or R	MARIE	DIKEM		Code)
1 and 2 Heath a Heath a tam 27 la		PAUL BRUNNER	/SON								MD.20758
0 80 E 54		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	Place of Dispo cemetery, cren	sition (Name of natory or other place	9)	Date	20c. Location -	City or To	wn, State
Baltim permit Pac Dept riment Important: any injury once.		21. Signature of Funeral Service		(1)	ĆĨ	Name and Addres	s of Eacility UNERAL B	IOME & CR	ARLING EMATORI	UM.P.	Α.
W 40 8		23a. Part1. Enter the disease, or	complications that of	caused the dea	0091 20	SOT CLEVE	LAND AVE	., KIVER	DALE, M	D. 20	0737 Approximate
Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aS	each line.	5.			,		>	Interval Between Onset and Death 2 School
Examiner	e	Sequentially list conditions, if any, leading to immediate	b. Due to	Yan I C	Sbs	stanch	ine Lu	ng dis	ease.	>	years.
os recuted physicien and the burial-transit	dicai Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(. I	lews (or as a consec				0		>4	days
.O. BOX of the death certification by the attending ached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	tcome of pregn pirth 2 Teta nant at time of cown	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	e of deliver	ry Day Year
Sign of be	þ	Part II. Other significent condition	ons contributing to di	-	sulting in the ur	nderlying cause give	n in Part I.			ibute to the	e cause of death?
Hec e law has b	Completed							24a. Was a autops perform	sy p rged? d	Vere autoportor to compleath?	sy findings available ipletion of cause of
OI VITAL P Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	ath Check only on			20 100
Physi Physi rthis o	ဥ	1 ☐ Yes 2 No	7		ER/Outpatien		4 Nursing F	lome 5 ☐ Reside)
E & 9	tion	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investic	9	of Injury th, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at ? ′es 2 ⊡No	28d. Describe ho	ow injury occurre	be	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	ertification;	2 Accident Investig 3 Suicide 6 Could i 4 Homicide determ	not be 28e. Place	of Injury - At h ng, etc. (Speci	ome, farm, stre fy)	eet, factory, office	63 2 110	28f. Location (SI City or Town	treet and Numbern, State)	er or Rural	Route Number,
Hospita 24 hours Funeral	edicai C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the ba	best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op-	e, date and place inion, death occu	, and due to the corred at the time, d	ause(s) and mar ate and place, a	nner as sta	ited. the cause(s)
To th within comp	Me	29b. Signature and title of certifie	0-			29c. License	number	2	9d. Date signed	(Month, D	lay, Year)
7		Kama	L K- 71	uli'		1190	509		may 1	y- 2	006
-		30. Name and address of person RAMAN R.	who completed caus						1		
Sta Regist		31. Date filed (Month, Day, Year)	2006	egistrar's Signa							***

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0 3 2006

32 Registrar's Signature

			State of State of State of State of State of State Registra AVEND#5perFH5/3/06, BMW,	Maryland / Dep	artment of He		ental Hygiene	2006	15535
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Feliciano Brandao				2. Date of Death Month Day	Vose	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and num Holy Cross Hospital 5. Social Security Number 108M 2 F	7. Age (In yrs. last birthday)	4b. City, Town, or L SIVEY If Under 1 Year Months Days	Spring		_ Country	ce (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			5-10-1938	Braz	I. Inside City Limits
	the Maryi	rector	mp Montgomery 10e. Street and Number	Silver S	Pring 101. Zip Code		10g. Citi	zen of What Country	1 □ Yes 2 No
	within 72 hours after death with the Maryland sne. sna "ratural", or items 23a or 28a-f show in Medical Examinar must be notified at	Funeral Director	11. Marital Status 1 Never Married 1 Never Married 2 Married 1 Yes	ces?	20906 Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto R	Bra offy Yes or No- lican, etc.)	14. Race - American Black, White, etc	
215-0036	'2 hours af	þ	3 Widowed 4 Divorced Year or Di	e tates:	1 ☐ Yes 25 No	Specify:	16b. Kir	Specify: Whi	te
2	filed within 7 Hygiene. other than "r ent, the Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	ral ASSIS	tant	Giov	rernmen	it
Maryland	2 should be filed within and Mental Hygiene. Is marked other than reumatic event, the Mental Mental than the M	To Be	17. Father's Name (First, Middle, Last) Feliciano De Souza (2) 19a. Informant's Name/Relationship (Type, Print)		(Brigida	(First, Middle, Maiden Candida Route Number, City or	da Silv	Q
Baltimore, Ma	of Health of Health filsm 27		20a. Method of Disposition 1♥ Burial 2 □ Cremation 3 □ Removal from 5 4 □ Donation 5 □ Other (Specify)	onter 1270 20b. Place of Dispo	osition (Name of	ra Rd.	Silverspr	cation - City or Town	20906 n, State
Baltir	permit. Pag Depertment Important: I sny injuny g		21. Signature of Funeral Service Licensee	mo1358 9	2. Name and Address	of Facility Ray	r Funeral	and Crem	iation.
	Pnysician /Medical Examiner	e.	Sequentially list conditions. b.	aused the death. Do not en ach line. or as a consequence of): or as a consequence of):	iter the mode of dying,	such as cardiac or	respiratory arrest,	In	pproximate nterval Between inset and Death
68760,	cate be executed physicien and the burial-transit	dical Examiner	that initiated events c.	or as a consequence of):					
P.O. Box 6	The law requires that the death certificat sie has been signed by the ettending phy page 2 should be detached for use as the	Physician/Med	in the past 12 months?	ant at time of death 5[☐Ectopic pregnancy ☐ Other (specify)		2	3d. Date of delivery Month Da	ay Year
	w requires that been signed t should be det	þ	Part II. Other significant conditions contributing to de	ath but not resulting in the u	underlying cause given	in Part I.	23e. Did tobacco us	se contribute to the d	cause of death?
al Records,	ician: The law re certificete has be rector, page 2 sho	e Completed	25. Was case referred to medical				24a. Was an autopsy performed?	24b. Were autopsy prior to compl death?	letion of cause of
ion of Vital	ding Phys h. After this funeral dii	ToB	examiner? 1 Yes 2 No Hospital: 1 1 28a. Date of Death	npatient 2 ER/Outpatien of Injury h, Day Year) 28b. Time of Injury	of 28c. Injury a	4 Nursing Hom	(Check only one) e 5 ☐ Residence 6 Bd. Describe how injury		
Division	F 8 5 7	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place building	of Injury - At home, farm, st ng, etc. (Specify)	reet, factory, office	28	Bf. Location (Street and City or Town, State)		oute Number,
	To the Hospital of within 24 hours at To the Funeral Discompletely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the band mann	isis of examination and/or in ier stated.	vestigation, in my opin	nion, death occurred	d at the time, date and	place, and due to the	e cause(s)
	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2	29b. Signature and title of certifier	e of death (Item 23a) (Type,	D 243	348	29d. Date	o signed (Month, Pay	v, Year) 20 G
	2		30. Name and address of person who completed caus The series of person who cause the s	e of death (Item 23a) (Type,	oForest G	ilen Rdi Si	Iver Sprin	g MD 20	0110
	Sta Registi		MAY 0 3 2006	we & A	enter		`	_	

			1 - For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Pag. No.							15536	
		1. Decedent's Name (First, Middle, Last)				2. Date of De			eath 3. Time of Death			
	Physici		Robert S Be	56				Month 4	29	Year 66	0539 A M	
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County		0001	
	ZXXIIII		Coastal Hospice At	the Lake		Salisba	end		Wicon	m 160		
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vand	9. Birthpl	ace (State or Foreign	
	Director		364-20-7549 ^{1X}	^{1M 2□ F} 79	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day 6/7/192	6 1	Michi	igan	
	P .	y Funeral Director	Usual Residence of Decedent									
	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "neture!; or iteme 23e or 28e-f ehow event. The Madical Examinar must be notified at		10a. State 10b. County	10c. C	ity, Town or Lo	eation				10	0d. Inside City Limits	
			Maryland Wicomic	o Sa	lisbur	У					1 ☐ Yes 2X No	
			10e. Street and Number 10f. Zip Code						10g. Citizen of What Country?			
			913 Loch Raven Road 2186				04	USA	USA			
			11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
9			1 Never Married 2 Married	1 X Yes 2 □ No	s 2 □ No Give Natro		1 ☐ Yes 2 X No Specify:			Specify: white		
g	urel',	d by	3 Widowed 4 Divorced	Year or Dates: INCLV	Y				Specify.	WI	1ce	
5	72 F	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup kind of work done	during most of work	ing	16b. Kind of Bus	siness/Ind	lustry	
2	athin hen hen		Elementary/Secondary (0-12) College (1-4or 5+)			DO NOT use retired)			automotive parts			
2	should be filed and Mental Hygi marked other tumatic event.		17. Father's Name (First, Middle, Last)		Sare	esman	40.14.15.4.11				parts	
E C		To Be	Charles H. Barr			18. Mother's Name (First, Middle, Ma. Margurite Karcher						
3												
Maryland 21215-0036			19a. Informant's Name/Relationship (Ty Mary Elaine Barr/	•			and Number or Rui				Code)	
_	s 1 and 2 f Health item 27 i	1	20a. Method of Disposition			sition (Name of	en Rd., Sa				31-1	
5	ges it of t		1 XBurial 2 ☐ Cremation 3 ☐ F	lemoval from State M=	cemetery, cren	natory or other place Veterans	ce)		20c. Location - (wn, State	
Ë	tmen tant:		4 □Donation 5 □Other (Specify)		emeter.	V	3,3,		Hurlock			
Baltimore,	permit. Pages 1 a Department of He Important: if item eny injury or othe		21. Signature of Funeral Service License	90	22	Name and Addre	Funeral I	Home Pro	fessiona	al As	sociation	
	40 = • a		Karts of Ke	reney (+5)		JOT DITOM	111111 11010	Dation	ury, HD	2180)4	
ш	Physician /Medical Examiner	Examiner	23a. Part t. Enter the disease, or complishock, or heart failure. List only or	ications that caused the dea ne cause on each line.	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between	
			Immediate Cause (Final disease or condition	LURE				Onset and Death				
			resulting in death) Due to (or as a consequence of):									
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	cate be executed physician and the burial-transit	am	that initiated events resulting in death) Last	D								
30,	oe ex	<u> </u>	and the state of t	Due to (or as a consec	quence or):							
8760,	ate by significant the b	dical		1.						-		
9	ling p	Me	IF FEMALE:									
Вох	leath certifi: attending ; I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 3 □Ectopic pregnancy					23d. Date of delivery Month Day Year		,	
	at the dei by the a stached f	sic	1 Yes 2 No	4☐ Pregnant at time of of 9☐ Unknown	death 5□	Other (specify)			William	\$1 L	Day 16a1	
P.0	that the death certificated by the attending of detached for use as	Ę.			41							
Ś	law requires the as been signed 2 should be de	þ							d tobacco use contribute to the cause of death?			
orc		ted	_ DEMENTIA					1 Yes 2 No 3 Probably 4 Unknown			ibiy 4 Unknown	
ec	e law has b	ple	HOTERTENSION.					24a. Was an autopsy 24b. Were autopsy findings av prior to completion of cau			sy findings available	
The base of the contract of th								perform	performed? death?			
ita	ling Physician: After this certific uneral director,	Certification; To Be C	25. Was case referred to medical examiner?				26. Place of Deat					
Ž			1 ☐ Yes 2/2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
Division of			27. Manner of Death 1 ØNatural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work? 28d. Describe how injury occurred Work?								
<u>S</u>			2 Accident investigation	M 1 □ Yes 2 □ No								
Ĕ	er de	ξ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (Str City or Town		or Rural	Route Number,	
	Hospital or Attend A hours after death Funeral Director: etely filled in by the to											
	Hospital	cai	29a. Certifier (Check only (Ch								ited.	
	To the Hosi within 24 ho To the Fund completely f	Medical	and manner stated.									
	5 \$ 5 6 V	4	29b. Signature and title of certifier	itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/74/66 Ses of person who completed cause of death (Item 23a) (Type, Print) W. 15AACS COASTAL HOSPILE AT LAKE SAUSTSURY MY								
•	inne		- Kanies 6									
	/Und	, i		impleted cause of death (Ite	m 23a) (Type, i	Print)	A		TEER	SHE	AT 7180	
	IVH		NAMES WO. 15+	TACS ('OF	ASTAC	HOSTIL	EAT	AKE	SAUS	1300	14 MAD	
	Sta	te	31. Date filed (Month, Day, Year) M \(\Delta \cdot \) 2. 2	32. Registrar's Sign.	ature	back)						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 29 29 APRIL GORDON R. BAER, JR. 2006 0924 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27013 BUNNY LANE **EASTON** TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye JULY 14, 5. Social Security Number Birthplace (State or Foreign Country)
 PA Funeral 7. Age (In yrs. last birthday) Year) 1925 Months Days Hours 1**X** M 2□ F 80 Yrs Director 165-24-9655 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumetic event, the Medical Examinar must be notified at 1 Yes XXNo Directo MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 'naturel', or Items 23a 27013 BUNNY LANE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumetic event. If a Me. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURE REP. REFRACTORY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GORDON R. BAER ANNA BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELISABETH M.N. BAER/WIFE 27013 BUNNY LANE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 5/1/2006 ^¹ 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 3 Joseph Ustrowsk. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ohoma Lym 44070 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physiclan/Medical as attending IF FEMALE: esn. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. ☐ Yes 2 ☐ No. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 🗌 Yes 2. No P 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) uneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; Injury at Work? After Natural Injury s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. EGLSEDEŔ, III 503 CYNWOOD DRIVE, EASTON, MD 21601 LUDWIG M.D. aegistrar's Signatu State Registrar

		•	For State Registrar	State of Ma	aryland		artmen tificate			Mental Hy	giene Reg. No. 0	36	15538
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) EVA N BROTT							2. Date of De Month	Day 2	Year JO6	3. Time of Death 5:46 AM
	Examin	_	4a. Facility Name (If not institution, give st LIFV 2-67 (12-7) 5. Social Security Number 6. Sex	AZ Ito	SPI TA		4	AU D	Location of De			cec	18072C, & S
€	Funeral Director		270-36-8261	M 2□F	66	Yrs.	Months	Days	Hours M	Apriliz	8°,1940	Ohio	lace (State or Foreign try)
	Maryland	tor	10a. State 10b. County Howard			Town or Lo	cation					1	0d. Inside City Limits
	h with the 23a or 28a	al Director	10e. Street and Number 9225 Q Brandy Lane		,		10f. Zip		0723		10g. Citizen of United		•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23a or 28a-f show entry for other traumatic event, the Madical Eratic artifical tendilliant apone.	by Funeral	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S No	. 13.1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Ra Bla Specij	ce - Americ ick, White, fy: Wh	
Baltimore, Maryland 21215-0036	d within 72 ho giene. or than "netu	Completed by	(Specify only highest grade [Elementary/Secondary (0-12)] [Elementary/Secondary (1-12)] [Elementary/Secondary (1-12)]		5+)	16a. Deced (Give life. I	kind of wor DO NOT us	k done d e retired,	luring most of v	vorking	16b. Kind of B		olustry
land	uld be file Mental Hy, rked other tic event,	0	17. Father's Name (First, Middle, Last) Gordon				Brott	-	18. Mother's N Eleano	lame (First, Middle T	, Maiden Surnai		chter
Mary	aith and h		19a. Informant's Name/Relationship (Type Tara Brott -daught							aurel, Ma			
more,	Pages 1 a tment of Hertant: If Item jury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Cer	netery, crer	natory or ol	her place		Date /2/2006	20c. Location	-	wn, State Virginia
Balti	permit Departm Importa eny Inju		21. Signature of Funeral Service Licenses	, peward	P	136 44	onala 400 Po	wde	30fgWar r Mill	dt Funera Road Belt	l Home, sville,	PA Mary	land 20705
8760,	ate be nysicia he bur	dical Examiner	g d										Approximate Interval Between Onset and Death 24 Its 46 Ims
P.O. Box 6	that the death certifics ed by the attending ph detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal c	leath 3	Ectopic pro					ate of delive	ory Day Year
	quires that the signed by all be detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions.										ne cause of death?
Reco	The law requir ate has been si page 2 should l	Completed	autopsy performed?									prior to cor death?	psy findings available impletion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical					Othe		leath Check only			
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation; To											/)
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)										l Route Number,
	e Hospital 24 hours a e Funeral I	Medical	29a. Certifier (Check only one) 1 Certifying Physical Cardinal Examin	cian: To the basis o ar: On the basis o and manner st	f examination	hedge, death on and/or in	h accurred investigation,	in my op	a date and da pinion, death or	ce, and due to the curred at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the complete	×	29b. Signature and title of certifier				1		number	-	MAY		Day, Year)
	3		30. Name and address of person who cor		death (Item :	23a) (Type,			,	· ·			+ mn 21044
100	Sta Registr		31. Date filed (Month, Day, Year)	1 00 0 111	rar's Signatu			ا ت	VY CUXL	INT VE	7 000	- F 4 1/2	+ mi) 21044

			For State	ricase		of Marylan	d / Depa	artmen	t of H	ealth a	and M	-	/giene	7 1 1 1 1	16	155	39	
			Registrar 1. Decedent's Name	(First Middle 1	ast)		Cei	rtificat	e or L	Jean		2. Date of D	Reg. No.	0		3. Time of	Death	
	Physicia	an										Month April	26. 2		Year	6:30		
	/Medic Examin		4a. Facility Name (If							Location of		Whrit	4c.	County of		0:50		
	LAGIIIII	е.	Holy Cros	ss Hospi	tal					Spri	_			ntgo	mery			
	Funeral Director		5. Social Security No. 120–12–69		Sex 1⊠M 2□F	7. Age (In yrs. 86		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	2, Year)	920	9. Birthpla New	rce (State o York	r Foreign	
	and w	-	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation							10	d. Inside Ci	ty Limits	
	Marylia f sho	0	MD	Montgom	ery	5	Silver	Sprin	ng							1 🗆 Yes	2 N 0	
	r 28a-	Director	10e. Street and Num					10f. Zip	Code				10g. Citi	izen of Wh	hat Count	ry?		
	th with	aiD	1111 Univ	versity	Blvd. W	., #1206	5	20	902				Un	ited	Sta	tes		
	ems erms	ner	11. Marital Status		12. Was De Armed F	cedent Ever in U. orces?	.S. 13.	Was Deced	dent of Hi	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race Black	- America , White, e			
36	s afte	by Funeral	1 Never Marrie 3 Widowed	ed 2∏ Married	1 PYes If Yes, G Year or	2 □ No live WW]	I	1 ☐ Yes	2⊠ No	Specify:				Specify:	Wh	ite		
ô	ture!	edit	0 🗆 7 7 7 7 7 7	15. Decedent's E		- Dutos	16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	ind of Bus	iness/Indi	ustry		
215	hin 72	Completed	(Speci Elementary/Secon	ify only highest g		(1-4or 5+)		kind of wo DO NOT u			t of work	ing	11 0	, _		_		
2	od with	Con	12				Lette	er Car	rrie							Serv	LC e	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show simportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any joury or other traumatic event, the Medical Examinar mounts and lifed at ADGE.	To Be	17. Father's Name (_	oom						ther	в (First, Middl Gr	e, Maiden eenfi)			
ary	and N		19a. Informant's Na	me/Relationship	(Type, Print)			-				al Route Num						
Σ,	and 2 ealth m 27 i		Eve Blo		ife	John F				ty B1		W., #		sation - C			ig, MD	
lore	ges 1 if of H or ot		14 Burial 2	☐Cremation 3	☐Removal from	1. 1 0	emetery, cre	matory or c	ther place	e) rden							\	
Ħ	rtmen rtant: njury		20a. Method of Disposition 14 Burial 2 Cremation 3 Removal from State 4 Donation # Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) King David Mem. Garden Apr. 30											hinsky Hebrew Funeral Home				
Ва	permit Depar Impor sny In		huh	w of	72yl		25	54 Car	rro11	L St.	, NW	, Wash	ingto				ome	
I			23a. Part 1. Enter the shock, or hear		mplications that y one cause on	caused the deat each line.	h. Do not en	ter the mod	le of dying	g, such as	cardiac	or respiratory	arrest,			Approximate Interval Bet Onset and I	ween	
	Physician		Immediate Cause (disease or conditio resulting in death)	Final n	a	SCVD										Years	3	
	/Medical Examiner		Tooling III additing	- 1	Due to	o (or as a conseq	uence of):											
	ñ	ē	Sequentially list con if any, leading to im	nditions, nmediate	b. Due to	o (or as a conseq	uence of):											
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.															
oʻ	be executed icien and burial-transit		resulting in death) Last Due to (or as a consequence of):															
8760,	ate be hysici the bu	licai		•	d													
89 x	The law requires that the death certificate be executed the see been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:		23c If yes c	outcome of pregna	ancy					1.00		and Date	of delivor			
Вох	eath c	cian	in the past 12	months?	1 Live	birth 2 □ Feta gnant at time of d	il death 3	⊒Ectopic p ⊒ Other (s _t						23d. Date Mont		•	/ear	
Ф. О.	at the de by the e	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□ Unk										LIDEO-E	1000 00		
	res that igned b be deta	by PI	Part II. Other signif	icant conditions	contributing to	death but not res	sulting in the c	underlying o	ause give	en in Part I		23e. Did	tobacco i	use contrib	bute to the	e cause of d	eath?	
rds	w require been sig should b	ed th		ar msar	LICIENC	У						1	Yes 2	I X No 3	3 🗌 Proba	ıbly 4 □l	Jnknown	
Vital Records,	e lawre hes bee je 2 sho	Completed										24a. Wa	s an	pr	or to com	sy findings		
æ		E O										per 1 ☐ Yes	fórmed? 2√∑ No		eath? □Yes :	2□ No		
/ita	slcian: Certifice	Be (25. Was case refer examiner?	red to medical	He spital:				Othe		e of Deat	th (Check only	one)					
of	di S	2	1 Yes 2 ☐ 27. Manner of Deat		Hospital: 1 [Inpatient 2 3	ER/Outpatie		Othe 28c. Injury	4 🗆 140	ursing Ho	ome 5 ☐ Re 28d. Describe)		
O	ding h. After fune	tion	1 Matural 2 ☐ Accident	5 Pending investigat	(Mo	onth, Day Year)	Injury	м	Work	k? Yes 2□	No			,				
Division	Atten r deal sctor	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not	be 28e. Pla	ce of Injury - At h		treet, factor	y, office			28f. Location	(Street an	nd Numbe	r or Rural	Route Num	ber,	
Ö	s afte	Certification:	4 Homicide		Dui	lding, etc. (Specia	ry)					City of 1	OWII, State	*)				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	23a Curthiar (Check only one)		aminer: On the	ha bast of my kno basis of examina anner stated.)	
	To the Within To the	Me	29b. Signature and	title of certifier				1	c. License					te signed				
			- > W	Selly	D	el Vecch.	0-1-0		174	45	7		Ac	in	28,	2006	7	
10	2+1		30. Name and add		o completed ca		т 23а) (Туре		len F	Rd.	Silv	er Spr	ing.	MD 2	0910			
6	St. Regist		31. Date filed (Mon	th, Day, Year)		Registrar's Signa	atura			,								
	riegist	Tell			2000	SURBAL.	10	-										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** Robert Daniel BECKLEY May 3, 2006 1615 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Fairplay 9103 Bob Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 25,1939 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**⊠** M 2□ F Maryland 66 Yrs. Director 216-48-7046 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Fairplay Maryland Washington Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21733 USA 9103 Bob Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) dairy farmer dairy farm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked oth jury or other treumatic even Katherine Elizabeth Foltz Robert Daniel Beckley Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9018 Bob Lane, Fairplay, Md.
e of Disposition (Name of Date Vickie Wiles - Daughter 21733 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Salem Reformed 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If eny Injury or once. Church Cemetery
P2. Name and Address of Facility 5/8/06 Hagerstown, Maryland 21. Signature of Euroral Service Licenspe MINNICH FUNERAL HOME 17415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mend monte /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) o 9□ Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, sign 1 be 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) .0 32. Registrar's Signature State Registrar

		1 - For Amend Item	State of Maryland ns 25,27,28a-f	Department of Health 300 Certificate of Death	Mental Hyg	giene 2006	1554							
		Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death							
Physic /Medi		DAVID MAS	ON CHEEZUM,	JR.	FEBRUAR	246 2006	1245 PM							
Exami		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	h	4c. County of Death								
		The Memorial	Hospita	birthday) If Under 1 Year If Under 24 Hrs	T = 0 : (B):	Talbot								
Funeral		5. Social Security Number 6. Sex 214-12-6851	M 2□ F 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day	v, Year) Coul								
Director		Usual Residence of Decedent			Aug.29	,1912 Mar	yland							
yland		10a. State 10b. County	-	own or Location			10d. Inside City Limits							
the Marylan r 28a-f show	tor	MD Carol	ine	Preston			1 ☐ Yes 2 🛣 No							
with the Maryland a or 28a-f show	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	ntry?							
- 5 €	a	3821 Payne Ro	ad	21655		United St	ates							
ter death	unei	The state of the s	Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,								
36 s after , or its	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 21 No	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite							
Po in it	ed t	15. Decedent's Educ	Year or Dates:	6a. Decedent's Usual Occupation		16b. Kind of Business/In	dustry							
15 in 72	piet	(Specify only highest grade	completed)	(Give kind of work done during most of wo. life. DO NOT use retired)	rking	TOD. THIS OF DUSTINGS ATT	dustry							
with the state of	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Farmer		Dairy/Po	u1trv							
De filectal Hyg	BeC	17. Father's Name (First, Middle, Last)	, ,	18. Mother's Nar	me (First, Middle,	Maiden Surname)								
should be nd Menta marked imatic ev	10 E	David Mason (Cheezum	Sara	h Butle	r								
Daluffice, Marylation bermit Pages 1 and 2 should be file Department of Health and Mental Hy mportant: if Item 27 is marked oth my in ury or other traumatic event	ľ	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailing Address (Street and Number or Ru	ural Route Numbe	r, City or Town, State, Zip	Code)							
es 1 and 2 should to the last and Ment filem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. Eleanor Cheezum/Spouse 3821 Payne Road, Preston, Mary 1												
it of H		20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Ro	ceme	e of Disposition (Name of efery, crematory or other place)	Date	20c. Location - City or To	•							
Pag ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specify)	Jun:	ior Order Cem. 2/1	1/2006	Preston,	Marylan							
permit f Departm Importer any in ur		21. Signature of Funeral Service License	6		1 Homo	DA								
4 405 40		22. Name and Address of Facility Framptom Functal Home, FA 216 North Main St. Federalsburg MD 2163: Approximate shock, or heart failure. List only one cause on each line.												
			e cause on each line.	Do not enter the mode of dying, such as cardial	c or respiratory arr	rest,	Approximate Interval Between Onset and Death							
Physician		Immediate Cause (Final disease or condition resulting in death) Severe cortic stenosis a. Severe cortic stenosis												
/Medical Examiner		7650king in double												
	٥	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):												
uted I ansit	Examine	cause. Enter Underlying Cause (Disease or injury												
executed in and ial-transit	Exa	that initiated events c resulting in death) Last	Due to (or as a consequen	ce of):	10000 B									
ate be executed hysicien and the burial-transit	dical	L _d		TELETION	m.									
tifical og phy as th	ledi			CERTIL										
Attanding Physician: The law requires that the death certific reath. r death. ector: After this certificate has been signed by the ettending p. by the funeral director, page 2 should be detached for use as i	by Physician/Me	230. Was decedent pregnant	Bc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de	1		23d. Date of delive	•							
deat deett	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death			Month	Day Year							
that the de ed by the detached	٩.	9 Unknown			T									
ires tha signed d be de	þ	Part II. Other significant conditions con	tributing to death but not resulting	ig in the underlying cause given in Part I.		bacco use contribute to the								
v requir been s should	ted	Figh	t resp Px		1 U Y	es 2.22No 3.☐Prob	oably 4 Unknown							
e law hes b	Completed	Coro	nany arteny Idration	disease	24a. Was a autop:	sy prior to co	psy findings available mpletion of cause of							
: The l	ပ်	dehu	dration	_	perfor 1 ☐ Yes		2 No							
sician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	ospital:	Out	ath Check only or									
Phys this al dir	2	1 ★Yes 2 ★ 0	1 parinpatient 2 LER	/Outpatient 3 DOA Other: 4 Nursing F b. Time of Injury at Work?		ence 6 Other (Specification)	y)							
or Attending Physician: The law requires that effer death. Director: After this certificate hes been signed by the funeral director, page 2 should be detail by the funeral director.	io ii	1 Statural 5 ☐ Pending	(Month, Day Year)	Subject										
death death ctor: / the	Certification:	3 Suicide 6 Could not be	02/04/2006 7 28e. Place of Injury - At home	:00 p.M 1 Yes 2 No			el Route-Number							
lor A effer Dire	erti	4 Homicide determined	building, etc. (Specify)	•	William	treet and Number or Ruran, State) Dutchmat Hill Manor	i's Lane,							
pita urs erai		29a. Certifier 12 Certifying Phys	Nursing hon ician: To the best of my knowle	doe, death occurred at the time, date and place	a, and due to the c	ause(s) and manner as s	tated =							
To the Hos within 24 ho To the Func completely f	edicai	(Check only 2 Medical Examination)	 On the basis of examination and manner stated. 	and/or investigation, in my opinion, death occu	urred at the time, d	date and place, and due to	the cause(s)							
To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	2	29d. Date signed (Month,	Day, Year)							
		Harou Laura	Jin R	D55484		2-6-2	006							
		30. Name and address of person who co	mpleted cause of death (Item 23			¥ 2								
		Dr. Hai-Ou J	in 219 S. W	ashington St., Eas	ston. M	D 21601								
St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature											
Regist	trar	FFR 0 20	106	13 Sugalles										

	Physici	an	1 - For Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland			e of Dea		2. Date of De	Reg. No. 2	0 0 6 Year	3. Time of Death
	/Medic Examir		JAMES LEROY 4a. Facility Name (If not institution, give s.				Town, or Locat	ion of Death	APRIL		ty of Death	11:45P ^M
	Funeral Director		3838 GLEBE MEADOW 5. Social Security Number 214-44-6788 Usual Residence of Decedent	MAY 7. Age (In yrs. ia 62	as <i>t birthday)</i> Yrs.	If Under Months	WATER r1 Year If Un Days Hou	nder 24 Hrs. Irs Min.	8. Date of Bis (Month, Da 8-1-1	th av Year	Cour	lace (State or Foreign
	h the Maryland rr 28a-f e how	Director	10a. State 10b. County MARYLAND ANNE ARU. 10e. Street and Number		, Town or Lo		o Code			10g. Citizen o		Od. Inside City Limits 1 ☐ Yes 2 🙀 No httry?
130	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hylgiene. Department of Hylgiene 27 is marked other than "natural representation only injury or other traumatic event, the Medical Examinar must be notified at Once.	by Funeral		NAY 2. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: VietN	İ		037 dent of Hispanic cify Cuban, Mex 2 No Spec		ecity Yes or No Rican, etc.)	UNITED 14. Ra BI Spec	ace - Americ ack, White,	ean Indian, etc.
21215-0036	within 72 houiene. then "natura the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	ation	16a. Dece (Give	kind of wo DO NOT u	al Occupation ork done during of se retired)	most of worki	ng	16b. Kind of	Business/In	
Maryland	hould be fited d Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) William Edgar		405 44-11		18. M	Mar	y Eliz	, Maiden Suma abeth C	lark	
ore, Ma	les 1 and 2 st of Health and if item 27 ie n or other traun		19a. Informant's Name/Relationship (Typ Dolores D. Cumming 20a. Method of Disposition 1 Buriai 2 X Cremation 3 Re	rs/ Wife 20b. Pic		Gleb	(Street and Nu Meado The of hther place)	w Way,			D 2103	37
banimore,	permit. Pag Department Important: i eny injury o		4 Donation 5 Other (Specify) 21. Signary 4 (Fundamental Secretary)	Ka.		. Name ar	ory nd Address of Fa		RGE P.		UNERA	
,000	Physician and // Medical Examiner and street	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a conseque	ence of):		hmiu					Approximate Interval Between Onset and Death
.O. DOY 0	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 S No 9 Unknown	c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3	Ectopic pr Other (sp					ate of delive	ry Day Year
necolus, r	w requires that been signed by should be deta	þ	Part II. Other significant conditions cont	ributing to death but not resul	ting in the u	nderlying c	ause given in Pa	art I.	23e. Did t		atribute to th	e cause of death?
		e Completed	25. Was case referred to medical				26. PI	lace of Death	24a. Was autor perfo	osy rmed? 2 No	Were autop prior to con death? 1 \(\text{Yes} \)	osy findings available inpletion of cause of
5	ttending death. ctor: After / the fune	Certification: To B	27. Manner of Death 117. Natural 2		R/Outpatien 28b. Time of Injury	M 2	Other: 4 8c. Injury at Work?	Nursing Hom	ne 5 🄀 Resid	dence 6 Ot	rred	Route Number,
5	교환병호		4 Homicide determined 29a. Certifier Check only 2 Modical Examina	building, etc. (Specify)	ledge, death	occurred	at the time, date	and place, a	City or Tov	vn, State)	. annor as st	atod
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29b. Signature and title of certifier	and manner stated.	and or th		License numb	er		29d. Date signe	ed (Month, L	
4	Sta Registr		30. Name an a dress of person with com 31. Date filed (Month, Day, Year)	apleted cause of death (Item 2	23a) (Type,	Cel	17 1815 119 D			MAY 01		1401

			State of Maryland / Dep State of Maryland / Dep Registrer Ce	artment of Health and M rtificate of Death		ene . No. 2006	15543							
	ye.		Decedent's Name (First, Middle, Last)		Date of Death Month	DayYear	3. Time of Death							
	Physicia /Medic		Harry Leo Crow, III		May 1	, 2006	2:05p M							
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death								
			Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth		gomery lace (State or Foreign							
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 105 – 40 – 7225 7. Age (In yrs. last birthday 17. Age (In yrs	Months Days Hours Min.	Month, Day, Y farch 24, 1	ear) Cour	ington, DC							
		1	Usual Residence of Decedent			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
	yland		10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits							
	e Ma	cto	Maryland Montgomery Rockvill	.e			1 ☐ Yes 🎖 🔀 No							
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g	. Citizen of Whal Cour	ntry?							
	ath w	rai	14213 London Lane	20853		USA 14. Race - Americ	an Indian							
	ler de	Funeral Director	11. Marital Status 1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,								
336	hours after death with the Maryland tural', or Iteme 23a or 28a-f ehow al Eventi or must be notified at	by	3 Widowed 4 Divorced Vear or Dates: 1959-62	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite							
5-0036	2 hor	ted	15. Decedent's Education (Specify only highest grade completed) (Giv.	edent's Usual Occupation a kind of work done during most of worki	16	b. Kind of Business/Inc	dustry							
21	within 72 ene. then "nai	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	1	ransportat ivision of								
N	be filed within 72 hours after death with the Marylar last Hygiene. Its Hygiene. Id other than "natural; or Itsme 23a or 28a-f ehow event, Its Medical Evantiner must be notified at			Meter Mechanic										
	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, I'le Ma	Be	17. Father's Name (First, Middle, Last) Harry Leo Crow, Jr.		o <i>(First, Middle, Ma</i> nerine Dr	oomgoole H	enslev							
2	should nd Men marke umatic	ဥ	-	ing Address (Street and Number or Rura										
	es 1 end 2 should b of Health and Ments if Item 27 is marked r other traumatic e		Leslie Gail Crow/ Wife 142:	13 London Lane, Roo	ckville,	MD 20853								
Ψ	Pages 1 neni of He int: If Iten iry or oth		Bullial 2 Cremation 3 Hemoval from State Fort Tingo	matory or other place) May	5,	c. Location - City or To	- 1 - 1 - 2							
	permit. Pages Depertment of Important: If It eny Injury or one		4 Donation 5 Other (Specify) Fort Lincoln Cemetery 2006 Brentwood, Maryland 1. Signatus of uneral Service Licensee Frequency Agricus Collegives Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901											
8 —	Ded Ded Many						MD 20901							
а			23a, Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one dause on each line,	iter the mode of dying, such as cardiac of	or respiratory arres	t.	Approximate Interval Between Offset and Death							
	hysician		Immediate Cause (Final disease or condition resulting in death)	rotory from/	1~0	7	Sun (
	/Medical Examiner		Que to (or as a consequence of):	vehie Polyons	- Die	200	40005							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	08/10 F 1 0/11004	700	71 - 1								
	te be executed ysicien and he buriat-transit	Examiner	Cause (Disease or injury that initiated events c	/	/									
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	# > e		d											
Xo	death certifica e attending ph od for use as ti	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ery							
о. В	a deatl he atte	Physician/Med	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year							
<u>Ч</u>	res thet the de signed by the a be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the	underhing cause gwen in Part I	23a Did toba	cco use contribute to the	a cause of death?							
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00	aw requir s been si 2 should l	Completed			24a. Was an	24b. Were aulo	psy findings available							
Ĕ	yeicien: The lav is certificate has director, page 2	шо			autopsy performe	d? death?	mpletion of cause of							
ita	ien: artifica ctor.	Bec	25. Was case referred to medical examiner?		(Check only one)									
<u> </u>	hyeid this ca	은	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatie			ce 6 ☐Other (Specifi	y)							
Ē	ing P	on:	27. Manner of Leath 28a. Date of Injury (Month, Day Year) Injury Injury	Work?	28d. Describe how	injury occurred								
isic	Attending in death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Stre	et and Number or Rura	I Route Number							
Division of Vital	al or A s efter il Direct id in by	Certification:	4 Homicide determined building, etc. (Specify)	reet, factory, office	City or Town,	State)	, riodio ivamba,							
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director: Afler th completely filled in by the funeral	edicai (29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, deal on the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as si a and place, and due to	tated. the cause(s)							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month,	Day, Year)							
1	SXI		1/ Illun Lecty / (!)	10556	/ /	CAY 1,	2006							
- (-			30. Name and address of person who completed cause of meath (Item 23a) (Type William R. Dooley, M.D 31 West Kirk	Print) Street, Chevy Ch	ase, MD 2	0815								
Pari	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 2006 32 Registrar's Signature	SAL										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** April 2006 16:43 Ernest Howard Christopher 28 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Dorchester 5005 Maple Dam Road Cambridge | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 26, 1923 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 18 M 2□ F Yrs. Director 83 Maryland 220-12-0408 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County Items 23a or 28e-f show 1 ☐ Yes 2 No Cambridge Director MD Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5005 Maple Dam Road 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: Specify: ρ white 3 Widowed 4 □ Divorced naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) wire cloth mfg. fabricator 8 other other treumatic event, permit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest H. Christopher Mabel Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4946 Maple Dam Road, Cambridge, MD Naomi Phillips 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/3/06 Dorchester Memorial Park Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Courshor disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): attending physician Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 DUnknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 100 1 Yes Division of Vital Physicien: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 the funeral 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After Certification; or Attending 1 Natural 5 Pending death. 16:43PM 1 ☐ Yes 2 📉 No Gunshot 4/28/2006 after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in at home 5005 Maple Dam Road 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do 44292 who completed cause of death (Item 23a) (Type, Print) Claude E. Koprowski, M.D. 1410 Nd OLFUMD. NO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

			1 - For State Registrar		Marylar	•		nt of H		ind M		Reg. No.	20	06	155	145
	Physici	an	Decedent's Name (First, Middle, Nicholas Bruno								2. Date of De	Dav	,	Year	3. Time of De	
	/Medi	cal	4a. Facility Name (If not institution,		her)		4b Cit	v Town or	Location of	f Death	May 3,		Ounty o	f Death	9:40	a.™
	Examir	ner	Somerford Place				40.00		ersto					ingt	on	
	Funeral			S. Sex	. Age (In yrs.	last birthday,	If Und	er 1 Year	If Under 2		8. Date of Birt (Month, Da	h			lace (State or Fo try)	oreign
	Director		214-09-7232	1⊠M 2□F	92	Yrs.	Month	S Days	Hours	WIII.	Sept.2	1,19	13	Conn	ecticut	
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or L	ocation							1	0d. Inside City L	imits
	Manyli f eho	ō	Maryland Wasi	nington		Hage	rstov	vn							1 Tes 2	
	r 28a-	Director	10e. Street and Number	<u> </u>				Zip Code				10g. Citiz	zen of W	hat Coun	try?	
	th with	aiD	18019 Putter Da	rive					21740)			USA			
	eme.	Funerai	11. Marital Status	12. Was Deced	dent Ever in U	J.S. 13.	Was Dec	edent of Hi	spanic Orig n, Mexican,	in? (Spe , Puerto l	cify Yes or No Rican, etc.)	- 1		- Americ White,	an Indian, etc.	
36	s afte , or it		1 ☐ Never Married 2 ☐ Marrie 3 🏝 Widowed 4 ☐ Divorced	d 1 ☐ Yes If Yes, Give Year or Da)		1 🗆 Yes	2 X No	Specify:				Specify:	W	hite	
21215-0036	within 72 hours after death with the Marylend ane. than "naturel", or iteme 23a or 28a-1 ehow he Medical Examinar munitse mydified at	Completed by	15. Decedent's		165.	16a, Dece	ident's Us	ual Occupa	ation			16b. Kir	nd of Bus	iness/Inc	lustry	
15	n ne	piet	(Specify only highest Elementary/Secondary (0-12)		4015+)	(Give	kind of v	vork done d use retired	lurina most	of workii	ng				,	
21	filed with Hygiene other the	E O	12	0		1	macl	ninist	:			manu	fact	urin	g	
P	2 should be filed withir and Mental Hygiene. Is marked other than surnatic event. The Mi	Be	17. Father's Name (First, Middle, La								(First, Middle,		Sumame)		
Z	should ind Men marke umatic	မ	Nichole Cianell:			1.51.44.11		10			imaver					
Maryland			19a. Informant's Name/Relationshi Patricia O. Tros		ichter						<i>i Route Numbe</i> nurmont					
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8760,	The law requires that the death certificate be executed to the last been signed by the attending physicien end page 2 should be detached for use as the burial-transit of	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consec or as a consec							2				
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of	Physicien: this certifice ral director, p	ဥ	1 Yes 2 100			ER/Outpatie			4 (1401		ne 5 Resid			(Specify	411116	
Division	Attending For deeth. actor: After by the funera	Certification:	1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could not 4 Homicide	ot be 28e. Place	of Injury - At h	Injury	М		rat (? Yes 2□N	No	28d. Describe h	Street and	d Numbe		Route Number,	
ā	To the Hospital or Attending Physicien: The within 24 hours after deeth. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physician: To the xaminer: On the ba	sis of examin	owledge, deal	th occurre	ed at the tim	ne, date and pinion, deat	d place, a	and due to the	cause(s)	and man	ner as st	ated. the cause(s)	
	o the tithin 2 o the amplet	Medical	one) 29b. Signature and title of certifier	and mann	er stated.		2	9c. License	number			29d. Date	signed	(Month.)	Day, Year)	
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			30. Name and address of person	no completed cause	of death (Ite	m 23a) (Tvne	. Print)	SUITE	12	5		3/9		ALEX	(CO 14)	
131	1-3		Partition Fox	brANFO	ors,	γ_{λ}	11116	Ma	ICAI	CA	MPUS	RA	77	1	1743	
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DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Ma		artment of Health and M rtificate of Death	1ental Hygie	-/ IIII	15546
	Physicia		Decedent's Name (First, Middle, Last) JOHN WELLS D	EBOW		2. Date of Death Month	Dey Yeer	3. Time of Death
	/Medic Examin		4e. Fecility Name (If not institution, give street and number) LORIEN © RIVERS	DE	4b. City, Town, or Location of Deeth BELCAME		4c. County of Deeth	RD
	Funeral Director		021-22-6534 ¹ŒM 2□F	76 (In yrs. last birthdey)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yes SEPT 22,	9. Birth 1929 MAS	pleca (State or Foreign ntry) SSACHUSETTS
	aryland show	25	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits 1 XYes 2 □ No
	the M	Director	MARYLAND HARFORD 10e. Street and Number		HAVRE DE GRACE 10f. Zip Code	10g.	. Citizen of Whet Cou	
	23a or		417 FOUNTAIN STREET		21078		USA	
36	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23a or 28a-f show the Modical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Merried 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Myes 2 New 19 Yes, Give Year or Detes: 1	lo	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Bleck, White Specify: BI	
215-0036	be filed within 72 hou tal Hygiene. d other than "natura event, it a Madical E.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	16a. Dece (Give	dent's Usuel Occupation a kind of work done during most of work DO NOT use retired)	ing 168	b. Kind of Business/Ir	dustry
212	filed with Hygiene other ths ent, Ite	Com	12		MMUNITION SPECIAL		JNITED STA	TES ARMY
⊆ _		To Be	17. Father's Name (First, Middle, Last) CHARLES DEBOW		BEATRIC	e (First, Middle, Mai E ROUSE		
Mar	12 s h ar ls treu		19a. Informant's Name/Relationship (Type, Print) PATRICIA DEBOW / SPOUSE		ing Address <i>(Street end Number or Run</i> OUNTAIN STREET, HA			
	of Healt fitem 2 r other		20a. Method of Disposition	20b. Place of Dispe			c. Location - City or T	
Baltimore,	Pag ment ent: i		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)			24/06 A	RLINGTON,	VIRGINIA
Ba	permit. Depart import any inj once.		21. Signature of Funeral Service Licensee	2	 Name and Address of Facility LISA SCOTT FUN 552 LEWIS STRE 	ERAL HOME	P.A.	MD 21070
	nysician		23a. Pent1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition	the death. Do not en			Dr. GRACE	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a consequence of):	70000			
ŀ,	155	Jer	Sequentially list conditions, in any, earling to immodate cause. Enter Underlying Cause (Disease or Injury	consecuence of)	1			year
	be executed sician and burial-transit	Examiner	that indiated events					
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rds, P.	quires that the de n signed by the a uld be detached f	by	Part II. Other significent conditions contributing to death but De week of A week of	it not resulting in the u	Inderlying cause given in Part I.	23e. Did tobac	co use contribute to t	1
Records,	The law require ate has been si page 2 should b	Completed	- Atnut Elphiller	S'ay		24a. Was an autopsy performed	d? death?	opsy findings available mpletion of cause of
Vital	ician: certific ector.	Be	25. Was case referred to medical examiner? 1. Was a 2. State Hospital:		Other	h (Check only one)		
o	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injur	y 28b. Time o	nt 3 DOA 4 Minursing Ho	me 5 Aesidence 28d. Describe how i	e 6 DOther (Special injury occurred	(y)
Division of	eath. or: Aft	catio	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
DIX	tel or Att rs after d el Direct ed in by	Certification:	4 Homicide determined 28e. Place of Inju	iry - At home, farm, st . (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	it and Number or Rura itate)	al Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of the desired Examiner: On the basis of and manner star	examination and/or in	th occurred at the time, date and place, exestigation, in my opinion, deeth occurr	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
	with To t	M	29b. Signature and title of certifier AMU	nny	29c. License number	29d. 5	Date signed (Month,	Dey, Year)
5	+ I VA		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print) More Mail Nd	Bel	Ar MY	21014
	Sta Registr		31. Date filed (Month, Day, Year) 32. Figistra MAY 0 3 2006	r's Signature	Marchail ad		,	

			For State Registrar	State of Ma	aryland		artmen <i>tificate</i>			and M		iene	21111	5 155	547
I	Physici	an	1. Decedent's Name (First, Middle, Last, Michael		nobyc	rkv					2. Date of Deat			3. Time of 0	Death
No.	/Medic Examir		4a. Facility Name (If not institution, give		TODYC	21.r A	4b. City,	Town, or	Location o	f Death	riay 2	1	County of De		141
	Lxaiiii		Shady Grove Adv	entist			Roc	kvi	lle				ontgoi		
	Funeral Director		5. Social Security Number 6. Security Number 126 – 1419	X 7. Age	83	st birthday) Yrs.	If Under Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day, 11/09/	/ _{Year)}	9. B	irthplace (State or Country) Ukraine	Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County			Town or Lo								10d. Inside City	Limits
	Ba-f sh	ctor	MD Montgom	nery	Rock	vill	.e							1 ☐ Yes	2 € No
	th with th	ai Director	1235 Potomac V	alley Ro	oad		10f. Zip	Code 208	50		10	0g. Citiz	en of What C	Country?	
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "Madical Exeminer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:		1	Vas Deced f Yes, spec			gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		4. Race - Aπ Black, Wh Specify:	encan Indian, ite, etc. White	
Maryland 21215-0036	d within 72 ho piene. Ir than "natur Ir e Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5-	-	16a. Deced (Give life. L	lent's Usua kind of wor DO NOT us Chef	k done d e retired)	tion uring most	of workir	99		of Busines		
yland	2 should be filed and Mental Hygie Is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Onufryi Drohoby			-					(First, Middle, M a Vouc	_	,		
nore, Mar	of Health		19a. Informant's Name/Relationship (Ty Stephen Drohoby 20a. Method of Disposition 1 \text{\text{\text{\text{P}}}Burial} 2 \(\text{\text{Cremation}} \) 3 \(\text{\tinte\text{\texi{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\texi{\text{\texi{\text{\text{\texi{\text{\text{\\texi\texi{\tex	rcky/Son	20b. Plac	148 se of Dispos	Rou	te ne of ther place	4 No	rth	ate 2	Lerv	ville cation - City o	N.Y.12 r Town, State	
Baltimore,	permit. Pag Department Important: any injuga once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 7 Funeral Service Licen		50	PĤ	†LTP	Addres	RTNA	LDI		AL S	SERVI	New Yor CE, P.A. ng, Md20	
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8760,	death certificate be executed to entition physicien and and for use as the burial-transit units.	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a Due to (or as a	te for consequent consequent	nce of):	ica	tore	1 {	Chi	lus	ce			
O. Box 6	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	2 🗌 Fetal de	eath 3 🗌	Ectopic pre Other (spe					23	3d. Date of de Month	olivery Day Ye	ar
rds, P	The law requires that the de site hes been signed by the page 2 should be detached	þ	Part II. Other significant conditions con	ntributing to death bu	t not resulting	ng in the un	derlying ca	use give	n in Part I.		23e. Did tob	4		o the cause of dea	
Vital Records,	The lar	Completed								_	24a. Was an autopsy perform	ied?	24b. Were a prior to death?	utopsy findings av completion of cau	railable ise of
<u> </u>	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				Othe			Check only one				
ō	Phy er this	2	27. Manner of Death	28a. Date of Injury (Month, Day		VOutpatient 3b. Time of		c. Injury Work	4 Livur		e 5 Resider			ecify)	
joi	Attending Physician: It death. ector: After this certific by the funeral director.	atio	1 Natural 5 Pending investigation	(Month, Day	Year)	Injury	м		? es 2 □ N	lo					
=	2 2 2 0	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home (Specify)	e, farm, stre	et, factory,	office		21	3f. Location (Stre City or Town,	eet and State)	Number or R	ural Route Numbe	97,
	To the Hospitel (within 24 hours at To the Funerel D completely filled in	edicai	29a. Certifier 1X Certifying Phys	sician: To the best of ter: On the basis of and manner stat	examination	edge, death and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	place, ar	nd due to the car d at the time, da	use(s) a te and p	ind manner a place, and du	s stated. s to the cause(s)	
) ;	Total	Me	29b. Signature and Title of certifier	odun	MC)	29c.	License	number	135	29	d. Date	gigned (Mon.	1h, Day, Year) 2006 2085	
			30. Name and address of person who co	mpleted cause of de	ath (Item 23	Ba) (Type, F	Cer	ter	Dr. F	Cock	CVILLE	4	MO	2085	0
No.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	y A	medi	9							

Ja- Nvia Debow- Davis

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

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	4	- 2	1 1	0. 3	- K.,

1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month D. May 7, 2006 JA'NYIA LANAE DEBOW-DAVIS **Medical Examiner** 0710 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 730 Old Post Road Aberdeen Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months 1 Days 10 Hours Director 215-75-0453 Country) MARYLAND 1 M 2X F 03/26/2006 Usual Residence of Decedent ì 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show MARYLAND HARFORD 1 Y Yes 2 No HAVRE DE GRACE death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 417 FOUNTAIN STREET 21078 UNITED STATES P Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married Yes BLACK Widowed If Yes, Give Year 1 Yes 2 X No specify. 4 Divorced Specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) i. Pages 1 and 2 should be filed within 72 timent of Health and Mental Hygiene. rtant: If item 27 is marked other than "v or other traumatic event, the Medical. Baltimore, MD 21215-0036 NEVER WORKED 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be JONATHAN LEE DAVIS NATALIE MARIE DEBOW ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATALIE M. DEBOW / MOTHER 417 FOUNTAIN STREET, HAVRE DE GRACE, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State JAMES UNITED CEM. 5/16/06 HAVRE DE GRACE, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LISA SCOTT FUNERAL HOME, P.A.

552 LEWIS STREET HAVRE DE CRACE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Sudden unexplained death in infancy (SUDI) Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical X UNPENDED physician a AMENDED item#23a,27,28a-f,perME,g857,7/12/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Completed certificate has been 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 1 🗸 Yes 2 No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifit 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ FR/Outpatient 3 DDA Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural subject in unsafe sleeping Pending Yes 2 No Fnd 5/7/2006 Fnd 6:45 am Accident 2 environment Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide Aberdeen MD730 Old Post Road determined (Specify) Found: residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. May 8, 2006 30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			For State Registrar		State of	Maryla		artmen				ental Hy		000	1551.0
	7		Decedent's Name (First,	Viddle, La:	st)					Journ	1	2. Date of De	Reg. No.	UUL	3. Time of Death
	Physic		Hilda D.	Davi	s							Month	Day	Yea	
) ·	/Medi Exami		4a. Facility Name (If not inst	itution, give	e street and numb	er)		4b. City,	Town, or	Location of	of Death		4c. 0	County of De	eath
			SACred L	leAR	+ Has	Dita	L	Cui	mhe	RIQ	nd		A	HeG	And
	Funeral	Г	5. Social Security Number	6. S		Age (In yrs	s. last birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. B	Birthplace (State or Foreign
1	Director		232-26-3932		□M 2 X F	90	Yrs.	Wichtins	Days	Hours		Oct. 7			eyser, WV
	and *		Usual Residence of Deceder 10a. State 10b. Co			100 0	ity, Town or L	ocation							1404 1-111 05 11 5
	anylan ehow	5				100. 0									10d. Inside City Limits 1 TypYes 2 □ No
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	iter d	Ę.	11. Marital Status 1 ☐ Never Married 2 ☐	Marriad	12. Was Decede Armed Force 1 ☐ Yes 2	es?	0.5.	Il Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spec n, Puerto P	rify Yes or No ican, etc.)	- 14	 Race - An Black, Wh 	nerican Indian, hite, etc.
36	I', or	by F	3 X Widowed 4 □ Dive		If Yes, Give Year or Date			1 🗆 Yes 2	X No	Specify:			3	Specify: TI	
ğ	72 hours af 'naturel', or dical Exam	ed		edent's Ed			16a Dece	dent's Usua	LOccupa	tion			10h Kin		hite
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ary	2 should and Men ie marke sumatic		19a. Informant's Name/Rela		ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	or or Rural	Route Numbe	or. City or	Town. State	. Zip Code)
Σ	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Josephine Ne	alis/	Daughter										and, MD 2150
Baltimore, Maryland 21215-0036	tem of He		20a. Method of Disposition	-			Place of Dispe	osition (Nam	e of	7	Da	te			or Town, State
Ë	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth				cemetery, cre	•	•		May 9				
Ħ	# 문원을	21. Signature of Euneral Service Licensee 22. Name and Address of Facility 23. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.												ser, W	IV
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			23a. Part1. Enter the diseas	e, or come	lications that ceu	sed the dea								2012	Approximate
	Medical Examiner physicien and physicien and the purial-transit	al Examiner	Sequentially list conditions, any, lacding to immediate ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	c	as a conse						dVC]			7-01-0013
.O. Box 687	death certiff e attending od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	1	d. 23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 ☐ Fet	aldeath 3□	Ectopic pre Other (spe					230	d. Date of de Month	elivery Day Year
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ta	an: tifice or, p	O	25. Was case referred to me	dical						00 Pt	1.50	1 ☐ Yes		1 🗆 Ye	s 2 No
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ठ	eral c		27. Manner of Death		28a. Date of It		28b. Time of		c. Injury : Work?	4 [] [Vul:		5 Resid			ecity)
0	tth.: Aft	E S	1 X Natural 5 □ Pe 2 □ Accident in	nding estigation	(Month, I	Jay Year)	Injury	м		os 2⊡N					
Division of	Attendi r death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be termined	28e. Place of	Injury - At h	ome, farm, str	eet, factory.	office		28	. Location (S	treet and h	Vumber or F	Rural Route Number,
	after Direct	ert	4 ☐ Homicide de	iooq	building,	etc. (Specia	fy)	7,				City or Tow	n, State)		and reduce realizable,
	spita nours nera / fille		29a. Certifier	ifying Phy	sician: To the be	st of my kno	owled e death	occurred at	the time	date and	NACE 20	Adje to the c	toxide) an	of managers	e statud
	P P P P P P P P P P P P P P P P P P P	edical	(Check only 2 Med one)	ical Exami	iner: On the basis and manner	or examina	ation and/or in	estigation, in	n my opi	nion, death	occurred	at the time, o	ate and pl	ace, and du	e to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of C	rtifier	- ^ ^			29c.	License	number		2	9d. Date s	igned (Mon	th, Day, Year)
)) / \ / \ / \		2/\/\	\wedge	10	L	5	42	51				
	j		30. Name an Address of per	s n who c	om, leted cause o	death (Iter	n 23a) (Type	Print)	<i>-</i>)	//	10	/	• 1.)	16	2006
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	Sta	te	31. Date liled (Month, Day, Y			strar's Signa	ature	··CIVE	100	1110	CICIU	1/11	.,0,	210	
	Registr		MAY 1	7 2006	De de la constante de la const	, M	Boom	as a							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Vaar Physician EUNICE VIRGINIA DOBSON 10:40 PM May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Pines Genesis HealthCare -Talbot Easton 8. Date of Birth (Month, Day, Y MAY 27, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Days 1 □ M 2 👿 F MARYLAND 97 216-01-5693 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examinar must be notified at Yes 2 No Director MD TALBOT OXFORD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 21654 508 S. MORRIS STREET TISA or Iteme 23e Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: þ 3 Widowed 4 Divorced netural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Importent: If Item 27 is marked other: eny injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES W. POPE IDA V. WHALEY ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SALLY D. GREENHAWK/DAUGHTER PO BOX 122, OXFORD, MD 21654 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) OXFORD CEMETERY 5/6/2006 OXFORD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA M. Ustizawski C.F.SP. Joseph 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician orunoma 07 rears /Medical Due to (or as a consequence of Examiner Sequentially list conditions, in any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transl Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical as the IF FEMALE: 9SF 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Dav 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ empolism 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Welanom 1 Yes 2□No 1 TYes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of al or Attending P s after death. Certification: Injury 5 Pending investigation Natural М 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 C Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ပ 5.2.06 use of death (Item 23a) (Type, Print) CHMAN'S MD 610 31. Date filed (Month, I 32 Registrar's Signature Day, Year) State D A 2008 Registrar

DHMH 17 Rev 1/2001

Eunice Dobson

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 2006 AUGUSTA H. DIAMOND 5:15AM M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Year AUG 16 1924 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 F MARYLAND 81 Yre 213-20-3103 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 FEDERAL ST., APT 52 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married_2 Married 1 ☐ Yes X No Specify: 3 Widowed 4 Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) SHIPPING SUPERVISOR POWDER LAXATIVE CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARGARET KATHERINE HADDAWAY WILLIAM RIDGEWAY HUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET C. DIAMOND/DAUGHTER 474 EDGEWATER RD., PASADENA, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State WOODLAWN MEMORIAL PARK 4/28/2006 EASTON, MARYLAND `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer until meloscoss Enaomelna year Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque ce of): avour ce IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 2. No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Checkly) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICE 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 Tes 2 No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00040020 4/25/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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death certificate be executed

P.O. Box 68760

Division of Vital Records.

Funeral

Director

ortant: if item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other treumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or instant injury or other trainment.

Baltimore, Maryland 21215-0036

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4	Examir	er -	Crofton Convales	cent Cente		ant birthday	If Under 1	Cı	ofto:	n	C. Date of Riv	Anı	ne Arı	undel
	Funeral Director		5. Social Security Number 6. Septime 212–42–1424	/ Age	92	ast birthday) Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Day Jan. 29	v, Year)	Wa:	place (State or Foreign intry) shington DC
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	vith the N or 28a-f	Direct	10e. Street and Number 401 Queens Court				10f. Zip (21666			10g. Citizen o	of What Cou	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, it is Medical Exactlical minal be indiffed at ance.	by Funeral Director		12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decede f Yes, speci	ent of His fy Cubar		gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White	ican Indian,
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,			30. Name and address of person who co	ompleted cause of d	eath (Item	23a) (Type	Print)_	<u>ノ</u> こ	Dr.	Adi	tya Cho	pra. M		9 C
			600 Ridgeli	HIVE	Su	ite+	+23	1 F	Ann	ap	0/15	MO	21	401
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uneral rector		5. Social Security Number 217–13–7745 Usual Residence of Decedent	6. Sex 1 M 2 X F	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	-	Min.	27, 1977	MAR MAR	YLAND
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After this certificate has been signed by the attending physicial funeral director, page 2 should be detached for use as the burial	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ United Variable	23c. If yes, of 1 Live by 4 Pregn 9 Unknown 9 Unknown tons contributing to the USE Hospital: 1 1 28a. Date (Month) 1 28e Place ling stigation 1 28e Place ling	irth ant at time of de own odeath but not r of Injury Day, Year) /2/2006 of Injury - At h	2 Fett 5 Oth esulting in the ur 28b. Time of In Find 6:15 ome, farm, street	al death 3 [er (Specify) Inderlying cause given by the control of the control o	of Death (Che other'4 Nu v at Work?	23e. Did 1 Y 24a Wa aut 1 Yes eck only one) irsing Home 5 28d. Describ Subject 28f. Location or Town	Month Itobacco use contrib Yes 2 No 3 s an 24b. Wopsy pr formed? de is 2 No 1 Residence 6 ✓ e how injury occurrer ingested dr (Street and Number State) 02 F. F	Day bute to the Probab /ere autop ior to com path? Ves Other: So d CUSS (or Rural	cause of death? by 4 Unknown sy findings available pletion of cause of 2 No
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28, Apr. 2006 Blanche Elizabeth Edwards 3:16 pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Anne Arundel 712 Oak Grove Circle Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours Min. Feb. 19, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕱 F Yrs. Feb. 63 1943 Director 255-66-9819 Usual Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County worle r than "naturel", or iteme 23a or 28a-f ehov the Wedical Examinar must be notified at 1 ☐ Yes 2 ☑ No MD Anne Arundel Severna Park Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene important: If item 27 is marked other than "naturel", or iteme 23a any lijury or other freumatic event, the Medical Exempter 2008. 21146 712 Oak Grove Circle USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Anne Arundel County 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Park D. Simmons Blanche E. Estes ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John P. Edwards, Jr./Husband 712 Oak Grove Circle, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation \$ ☐ Other (Specify) 21. Signature of Foneral Service Licensus Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D free ediate Cause (Final disease or or ndition resulting in death) METASTASIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 2/00 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Pface of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Delatural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 15d Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiel and manner stated. 29b. Signat 29d. Date signed (Month, Day, Year) ATT RD 300 AMUA 31. Date filed (Month, Day, State Registrar

			For State Registrar	State of Ma	arylan		artmen rtificat			and M		Reg. No. 2	006	15	555
ł	Physici		Decedent's Name (First, Middle, L DONALD ROBE)		LI						2. Date of De. Month APRIL	ath Day 30	Year 2006	3. Time of 7:35	Death P ^M
	/Medic Examin		4a. Facility Name (If not institution, ga	ve street and number)			4b. City,	Town, or	Location of	of Death			unty of Death		
	LXIIII		6001 Muncaster M	ill Road-Ca	sey	House		Roc	kvil	le		Me	ontgome	ery	
I	Funeral Director		5. Social Security Number 6. 578-52-6376	Sex7. Age 1)21 M 2□ F	67	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Dec. 9	th ly, Year) 1938		olace (State on ntry) ington	
	pu ,		Usual Residence of Decedent		10+ Cit	y, Town or Lo	ontine.							I0d. Inside Ci	A. I imita
	Marylar -f show	ţō	Md. Monto	gomery		Gaithe		g						1 ☐ Yes	
	with the	Direc	10e. Street and Number 23713 Pleasant	View Lane			10f. Zip	Code	208	382		•	of What Cou	,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural; or items 23e or 28e-f show may injury or other traumatic event, it a Medical Evantical roast be notified at once.	y Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give		-	Was Deced If Yes, spec			gin? (Spi i, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White,		
5-0036	72 hours natural', lical Ex	eted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's I (Specify only highest g	Year or Dates:		16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa	tion uring mos	t of work	ing		of Business/In		
2121	d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		eet M					Cor	struct	ion	
Maryland 2121	ild be filed lental Hygid Ked other ilc event, I	To Be (17. Father's Name (First, Middle, Las Nicholas Fine							or's Name Lizal	e (First, Middle, oeth	, <i>Maiden S</i> u V i a	mame)		
ary	should and Men s marke umatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Run	al Route Numbe	er, City or T	own, State, Zip	Code)	
	and 2 Balth a n 27 Is		Hazel L. Finel	li / Wife			\$100 M. AW.		Viev		ne, Gai				82
altimore,	Pages 1 nent of He int: If Iten		20a. Method of Disposition 1. ☑ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		0	Place of Dispo cemetery, crei plar S	matory or o	ther place	·		1/06		tion - City or To ar Spri		id.
Baltir	permit. Page Department (important: if any injury of		21. Signature of Funeral Service Lice	ensee	10	22	2. Name an Murie	d Addres	s of Facilit Bark	y oer I	Funeral	Home			
			23a. Part1. Enter the disease, or co	nplications that caused	the death						Laytons'		, Ma.	20882 Approximat	е
	Physician /Medical Examiner	ılner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury		UNG a consequence									Interval Bet Onset and I	Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transitions.	Physician/Medical Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):									
P.O. Box 6	res that the death certific igned by the attending p be detached for use as	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	death 3	□Ectopic pr □ Other (sp					230	I. Date of delive Month		/ear
	quires that n signed b ald be deta	<u>م</u>	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying c	ause give	n in Part I.			obacco use Yes 2□N	contribute to the	he cause of d pably 4 □U	
Division of Vital Records,		Completed						-			24a. Was autor perfo 1 Yes		24b. Were auto prior to co death? 1 ☐ Yes	psy findings mpletion of c	available ause of
ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Harabali.				100		of Death	Check only o	ле)			
on of \	ding Ph h. After th funeral	tlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju. (Month, Da)		ER/Outpatier 28b. Time o Injury		8c. Injury Work	4 🗆 140		me 5 Resident			y) HOSE	PICE
Divis	= = = =	Certification:	3 Suicide 6 Could not determine				reet, factory	, office			28f. Location (3 City or To		lumber or Rura	I Route Num	ber,
	To the Hospitel of within 24 hours ef To the Funerel D completely filled in	Medical C	29a. Certifier 1. Certifying I (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
	rothi vithin rothi	Me	29b. Signature and little of certifier	1			290	. License	number			29d. Date s	igned (Month,	Day, Year)	
)	8		1/4		<u>~'</u>			D 35	635			1	MAY 1,	2006	
			30. Name and address of person wh					L RC	AD,	ROCK	VILLE,	MD.	20855		
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 3 20	32. Registra	ar's Signa	iture	Carre Carre								

GREENFIELD

٠			State of Maryland / Depart	artment of Health and Menta etificate of Death	
Physicia /Medic Examino	al	1. Decedent's Name (First, Middle, Last) Arthur Louis (4a. Facility Name (If not institution, give st Civista Medical Ce		Mo	pril 27, 2006 4c. County of Death Charles
Funeral Director		Social Security Number 6. Sex	M 2 F 7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min. (M	ste of Birth onth, Day, Year) 9. Birthplace (State or Foreign Country) 4. 23, 1938 Maryland 10d. Inside City Limits
72 hours after death with the Maryland natural; or Items 23a or 28a-f ahow used Examiner must be mulfied at	Funeral Director	MD Charles 10e. Street and Number 2561 Mattawoman	Waldor Beantown Rd.	10f. Zip Code 20601	1 X Yes 2 □ No 10g. Citizen of What Country? USA
ours after death w rai', or items 23a Exeminer oust	þ	11. Marital Slatus 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes ※ No Specify:	es or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
d within giene. rr then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	completed) (Give life.	deni's Usual Occupation kind of work done during most of working DO NOT use retired) illed Labor 18 Mother's Name (First	Union 456 Middle, Maiden Surname)
should and Mer is marke	To Be	McKinley Greenf: 19a. Informant's Name/Relationship (Typ. Mary Greenfield,	ne, Print) 19b. Mailin	Elsie Gre	
permit. Pages 1 and 2 Department of Health Important: if Item 27 any Injury or other trr any Injury or other trr		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □Rc 4 □ Donation 5 □ Other (Specify) 21. Signature of Upper II Severe License.	St. Pete	sition (Name of matory or other place) er's Ch. 5/4/06	20c. Location - City or Town, State Waldorf, MD Funeral Home, PA
Physician		Jan 3	19/ 2	0605 Aquasco Rd, er the mode of dying, such as cardiac or resp	Aquasco, MD 20608
Medical pe executed ician and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C X A Due to (or as a consequence of): D S N A C C Due to (or as a consequence of): S I PEG to	n be	
that the death certificate that the death certificate by the attending physical detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
e law requires has been sign	Completed by PI	Part II. Other significant conditions con	tributing to death but not resulting in the u	2-	3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 4a. Was an autopsy performed? Yes 2 No 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Probably 4 Unknown
ng Physician: tter this certifica	To Be	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 FVOutpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	26. Place of Death Che	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certification:	3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, farm, str building, etc. (Specify) ician: To the best of my knowledge, deat	Ci	ocation (Street and Number or Rural Route Number, ity or Town, State) 19 to the cause(s) and manner as stated.
To the Ho within 24 h To the Ful completely	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier	er: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the second s	he time, date and place, and due to the cause(s) 29d. Date signed (Menth, Day, Year)
Sta Registr		Manisha J. Jariwa 31. Date filed (Month, Day, Year)	mpleted cause of death (ftem 23a) (Type, La, MD 11637 Terrac 32. Restrar's Signature	e Drive Suite 103 Wal	ldorf,Maryland 20602

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11, May 2006 3:29 A Florence K. Gallagher /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Manresa Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 7-21-1927 Director 78 New York 577-32-5925 Usual Residence of Decedent 10c. City. Town or Location 10d. fnside City Limits 10a. State 10b. County or 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner truet be notified at 1 ☐ Yes 2 XNo Directo Sunderland Maryland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20689 USA 5781 Highland Lane filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 [XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Coffege (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 11th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event 2018. Be Viola Gerritsen Peter Danzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5781 Highland Ln., Sunderland, MD 20689 John M. Gallagher/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD Kalas Crematory 5-12-06 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Xears 2Mentia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of) Box 68760, Physician/Medical the r use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ō in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Hrknown Be Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 5515 Aug / 1016 1 ☐ Yes 24 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu investigation death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 11 0025499 0 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ritchie Highway Amold, anD 21012 1460 Ames 3. Registrar's Signature 31. Date fifed (Month, Day, Year) State 7 2006 Registra MAY

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	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-15-		9. Birthpla	
	or death with the Maryland tems 23a or 28e-f show at reast be neithed at	Director	10a. State 10b. County MD. P.G. 10e. Street and Number		10c. City, Town or Lo	e Hills		10	g. Citizen of		d. Inside City Limits **TYPE 2 No
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Baltimore	permit. Pages 1 Department of H Importent: If ite any Injury or of once.		21. Signature of Funeral Service Licer		22	. Name and Addres		lliams	Arl. Fun. W.		1
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Divis	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	al Certification:	3 Suicide 4 Homicide 6 Could not b determined	28e. Place of Injury building, etc.				If. Location (Stre City or Town,	State)		
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	Sta Registi		30. Name and address of person who Michael Side (1) day (3). Date filed (Month, Day, Vear) MAY 0 3 2	completed cause of dea	ath (Item 23a) (Type, I	Print) (ivings-	to Rla	#10/1	ff by	4 shyt	a MA 0745

State of Maryland / Department of Health and Mental Hygiene Reg. No. UUD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 28, 2006 **Physician** 10:00 P M Joyce Ann Hover /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis Elder Care Corsica Hills Ctr. Oueen Anne's Centreville 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛱 F Yrs. 577-50-6204 69 Washington, DC Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, it is Moulcal Extending to use be multilled at 1 Yes 2 No Maryland Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 640 Mecklenburg Ave., Apt. 324 21601 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Office Manager Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Cook John Hancock 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Cheryl A. Spencer/ Daughter 2635 Cox Neck Rd., Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 5-2-06 Suitland, MD 21. Signature from the rvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma of the lung with metastases **Physician** ears /Medical **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ▼No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause ot death (Item 23a) (Type, Print) Dutchmens Leve Easton, MID 21601 MD 610 32. Registrar's Signature State Registrar

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	15		30 Name and address of person who con	pleted cause of death (Item	1 23a) (Type,	Print)					
	10		Linda M. Burrell	, M.D. 2730	Unive	ersity 1	Blvd, #4	00, Wh	eaton,	MD 2090	2
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		1	For State Registrar		State of	Marylan		artmer rtificat			ınd M		Reg. No				161
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	/Medic	al -	4a. Facility Name (If not institution		reet and num			4b City	Town or	Location o	f Death	April		County of I		9.20	P
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparantent of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or liteme 23a or 28a-1 show simply or other traumatic event, the Marical Examinational to notified at Angles.		21. Signatur of Funeral Service		• ^	1200						Funeral			α,	1191	Lu
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.O. Box 6	that the death certificat led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23	1 Live bi	come of pregn rth 2 Feta ant at time of c	al death 3	□Ectopic p □ Other (s						23d. Date o Month		ry Day	Year
<u>α</u>	w requires that the been signed by th should be detache	by	Part II. Other significant condit Hypertension, C		-		-		cause giv	en in Part I.		,		use contribu			
Records,	sician: The law re certificate has be irector, page 2 sho	Completed	Chronic Renal F		·			ctive	e-Pul	monar	y _	24a. Was auto perfi 1 \(\text{Yes} \)	psy ormed?	prio	r to con	osy finding apletion o	s available cause of
Vital	ysician: is certifica director, p	Be C	25. Was case referred to medical examiner?	al I		inc croff	300	10,000	1.		of Deat	h (Check only	one				
of V	Physician: this certific ral director,	၉	1 ☐ Yes 2 🗷 No	н		npatient 2	-				irsing Ho	me 5 Res			(Specify)	
n c	fter fter	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pend		28a. Date o (Monti	of Injury h, Day Year)	28b. Time Injury		28c. Injur Wor	yat k? Yes 2 🗍	No	28d. Describe	now inju	ry occurred			
Division	Lor Attendi after death. Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could	igation not be nined	28e. Place buildir	of Injury - At h	nome, farm, s					28f. Location City or To	(Street ar wn, State	nd Number	or Rura	Route N	um ber,
	To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by th	Medical C				asis of examin						and due to the red at the time					e(s)
	To the within 2 To the complet	Me	29b. Signature and title Amerifi	ər	. (1		2		e number			29d. Da	te signed (/	Month, i	Day, Year)
			> 16.7111	icun	VAMV	UNV			d53	367				May	1,	2006	
	1		30. Name and address of person														
	φ		Shyamsundar Ra					ood (Court	, #1C	5, (Olney,	Mary	land :	2083	2	
	St Regist	ate rar	31. Date filed (Month Adv. You	2 20	006 32.	egistrar's Sign	nature /	parti	,								

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural, or Items 23a or 28a-4 show any injury or other traumatic event, the Medical Eracin at must be notified at once. Baltimore, Maryland 21215-0036

Physicia /Medic Examin

Funeral Director

	Physician /Medica Examine	
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner
	-	

Hackett, Lisa M

Name

	1 - For State Registrar	State of Ma		rtificate of De			eg. No.2 0	06	15562
	1. Decedent's Name (First, Middle, Last,)				2. Date of Deat			3. Time of Death
ın	LISA	N.	HACKETT	n		April	Day	Year 006	1237 P-M
ål	4a. Facility Name (If not institution, give		IIACIALI	4b. City, Town, or Lo	cation of Death	при	4c. Count		1.0.0)
er							40. 000111	y OI Death	
	St Agnes Hospi		//m look binkb da	Baltir	Nore Under 24 Hrs.	0.0			
	5. Social Security Number 6. Sec	x 7.Age]M 2.DXF	(In yrs. last birthday,		Hours Min.	8. Date of Birth (Month, Day, Mar. 9,	Year) CE	9. Birthr	place (State or Foreign yland
	21/-92-0965		41 Yrs.			Mar.9,	1965	Mar	yrand
	Usual Residence of Decedent 10a. State 10b. County		10a City Town and						
_			10c. City, Town or L					1	IOd. Inside City Limits
cto	MD Howard		Wes	st Friends	ship				1 ☐ Yes 2 XNo
ě	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
Completed by Funeral Director	13754 Old Ro	F.G. xox		21-	70.4			_	
era		12. Was Decedent E	verin IIS 13		794	oifu Vac as No	U.S	e - Americ	an Indian
Ë	1 X Never Married 2 Married	Armed Forces?		Was Decedent of Hispa If Yes, specify Cuban, I	Mexican, Puerto F	Rican, etc.)		ck, White,	
Ž	3 Widowed 4 Divorced	1 ☐ Yes 2 N If Yes, Give	9	1 ☐ Yes 2 ☐ No 5	Specify:		Specif	v: 12.1	ack
o p		Year or Dates:						, рт	ack
ete	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Occupations work done duri	n na most of workin	a	16b. Kind of B	usiness/In	dustry
ġ.	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired)	3				
Ö	12th			Domestic			Hom	e	
Bec	17. Father's Name (First, Middle, Last)			18	. Mother's Name	(First, Middle, M	Aaiden Sumar	ne)	
0 0	James E. Smi	+h			ualan	Hacke	d., d.,		
F	19a. Informant's Name/Relationship (Ty		10h Maili	ing Address (Street and				Ctata Tia	Codel
	Helen Foreman-	Mother	13/5	4 Old Rov					
	20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ F	Compunition State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Da	ate :	20c. Location	City or To	own, State
	'4 □Donation 5 □ Other (Specify)	temoval from State	1	ark Cem	1/29	/06	Cooke	1	1 MD
1	21. Signature of Funeral Service Licens	99 ∤	1 /-22 2	2. Name and Address of	f Facility C	7 U O	Cooke	SVII.	IC, MD
-	Took	Λ	a Atta	2. Name and Address of	2010	waen r	unera.	T HO	me, PA
	X A	neu		46 N. Was				LIE,	
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne caus <i>e</i> on each lin	ine death. Do not en 3.	ter the mode of dying, s	uch as cardiac or	respiratory arre	est,		Approximate Interval Between
y,	Immediate Cause (Final disease or condition	Acortion	Tomas	unodetrici	Purt 5	Van Change	63		Onset and Death
	resulting in death)	a Due o (or as a	consequence of):	und a cirici	che j	marom		_	years
			, ,						
6	d any landrate introdute	Ona to for as a	consecuence of					-	
를	cause. Enter Underlying Cause (Disease or injury								
la l	that initiated events resulting in death) Last	D							
<u> </u>	1555King in dod.ii) Edst	Due to (or as a	consequence of):						
edical Examiner		d							
ed									
ξ	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o	f pregnancy				23d Da	te of delive	AD/
<u> </u>	in the past 12 months?	1 Live birth 2 4 Pregnant at t		□Ectopic pregnancy □ Other (specify)				nth	Day Year
ysi	1 □ Yes 2 □ No 9 ☑ Unknown	9□ Unknown	and or additi						
Physician/	Part II. Other significant conditions cor	atribution to death but	not recultion in the	endorhina ar	Dort I	Ogo Dida:	**********	alleriae en re	an annual of desired
ò	Part II. Other significant conditions cor			. 0	ranti.	23e. Did (00			ne cause of death?
Completed by	I hrom DOTIC	Ihromb	ocytop	ienic tur	pura	1 □ Ye	s 2 No	3 Prob	ably 4 □Unknown
et			, ,		1	24a. Was ar	24b.	Were autor	psy findings available
Ĕ						autopsy	/	prior to condeath?	npletion of cause of
									2 🗆 No
Be	25. Was case referred to medical examiner?	facultud.			. Place of Death	Check only one)		
0	1 ☐ Yes 2 No	lospital: 1 Inpatier	t 2 ER/Outpatier	nt 3□ DOA Other:	4 🗌 Nursing Hom	e 5 🗆 Reside	nce 6 Oth	er (Specify	1)
			28b. Time o			d. Describe ho			
-	27. Manner of Death	28a. Date of Injury	Year) Injury	Work?					
atioi	1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) Injury		2 🗆 No				
fication	1 PNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, sti	M 1 Yes		Bf. Location (Str	eet and Numh	er or Rura	l Route Number,
ertification	1 ☑Natural 5 ☐ Pending investigation		y - At home, farm, sti	M 1 Yes		3f. Location (Str. City or Town,	eet and Numb State)	er or Rura	l Route Number,
Certification	1 PNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	y - At home, farm, sti (Specify)	M 1 ☐ Yes	28	City or Town,	State)		
ical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examin	28e. Place of Injuing, etc.	y - At home, farm, sti (Specify) my knowledge, deat examination and/or in	M 1 ☐ Yes reet, factory, office h occurred at the time, o	28 date and place, ar	City or Town,	State)	nner as st	ated.
edical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physical Examination	28e. Place of Injunbuilding, etc.	y - At home, farm, sti (Specify) my knowledge, deat examination and/or in	M 1 ☐ Yes	28 date and place, ar	City or Town,	State)	nner as st	ated.
Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Medical Examin	28e. Place of Injuing, etc.	y - At home, farm, sti (Specify) my knowledge, deat examination and/or in	M 1 ☐ Yes reet, factory, office h occurred at the time, o	date and place, aron, death occurred	City or Town, and due to the call at the time, da	State)	nner as stand due to	ated. the cause(s)
Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physical Examination	28e. Place of Injuing, etc.	y - At home, farm, sti (Specify) my knowledge, deat examination and/or in	M 1 ☐ Yes reet, factory, office h occurred at the time, ovestigation, in my opinion	date and place, aron, death occurred	City or Town, and due to the call at the time, da	State) use(s) and ma	nner as stand due to	ated. the cause(s)
Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Place of Injurbuilding, etc. sician: To the best of ner: On the bass of and manner stat	y - At home, farm, str (Specify) my knowledge, deat examination and/or in ed.	M 1 ☐ Yes reet, factory, office h occurred at the time, ovestigation, in my opinion 29c. License nu	date and place, aron, death occurred	City or Town, and due to the call at the time, da	State) use(s) and ma	nner as stand due to	ated. the cause(s)
Medical Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Cartifying Physical Examination	28e. Place of Injurbuilding, etc. sician: To the best of ner: On the bass of and manner stat	y - At home, farm, str (Specify) my knowledge, deat examination and/or in ed. At (Item 23a) (Type,	M 1 ☐ Yes reet, factory, office h occurred at the time, ovestigation, in my opinion 29c. License nu Print)	date and place, aron, death occurred	nd due to the ca	use(s) and mate and place,	nner as st. and due to	ated. the cause(s) Day, Year)
Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who co	28e. Place of Injunbuilding, etc. sician: To the best of ner: On the pass of and manner stat	y - At home, farm, str (Specify) my knowledge, deat examination and/or in ed. Agnes Hos	M 1 ☐ Yes reet, factory, office h occurred at the time, ovestigation, in my opinion 29c. License nu	date and place, aron, death occurred	nd due to the ca	use(s) and mate and place,	nner as st. and due to	ated. the cause(s)
Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who co	28e. Place of Injurbuilding, etc. sician: To the bist of ner: On the pass of and manner stat	y - At home, farm, str (Specify) my knowledge, deat examination and/or in ed. Agnes Hos	M 1 ☐ Yes reet, factory, office h occurred at the time, ovestigation, in my opinion 29c. License nu Print)	date and place, aron, death occurred	nd due to the ca	use(s) and mate and place,	nner as st. and due to	ated. the cause(s) Day, Year)
Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who co	28e. Place of Injunbuilding, etc. sician: To the best of ner: On the pass of and manner stat	y - At home, farm, str (Specify) my knowledge, deat examination and/or in ed. Agnes Hos	M 1 ☐ Yes reet, factory, office h occurred at the time, ovestigation, in my opinion 29c. License nu Print)	date and place, aron, death occurred	nd due to the ca	use(s) and mate and place,	nner as st. and due to	ated. the cause(s) Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Hagerstown

21740

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

10f. Zip Code

1 ☐ Yes 2 ĀNo Specify:

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

Maryland

10g. Citizen of What Country?

Specify:

18. Mother's Name (First, Middle, Maiden Sumame)

340 MILL BIRELT, HALEPSTOUN, MD 21740

Mary Alice Bryan

U.S.A.

16b. Kind of Business/Industry

Race - American Indian, Black, White, etc.

Tax Office

White

21740

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

10d. Inside City Limits

1 DXYes 2 □ No

State of Maryland / Department of Health and Mental Hygiene
Amend Items 24a,27 per Dr., G855 Of 116 (16 dh) eath

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Mildred Louise Harbaugh April 29, 2006 /Medical 3:11 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Beverly Health Care Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Months 1□ M 2□XF Yrs. 83 216-14-6587 March 31,1923

10c. City, Town or Location

Director

Usual Residence of Decedent

1 ☐ Never Married 2 X Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Neme (First, Middle, Last)

12

10b County

Washington

15. Decedent's Education (Specify only highest grade completed)

Rush O. Hawbaker

1747 Edgewood Hill Circle Unit #103

12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

BELARVM, HD

32. Registrar's Signature

10a. State

Maryland

11. Marital Status

10e. Street and Number

Directo

Funeral

ģ

Completed

Be

filed within 72 hours after death with the Maryland show r than "natural", or itams 23a or 28a-f shov the Madical Examinar must be notified at 99

marked other and Mental . Pages 1 end 2 should be tment of Health and Menta tant: If item 27 is marked Depertment of Health Important: If item 27 any injury or other to once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ģ After this certificate hes been signe funeral director, page 2 should be or Completed Be Certification: To efter death.

Director: Aff
d in by the fur completely filled in by 24 hours e

Medical

State

Registrar

PRAYEEN 31. Date filed (Month, Day, Year)

MAY 1 6 2006

Division of Vital Records, P.O. Box 68760,

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1747 Edgewood Hill Circle Unit # 103 Hagerstown, MD Paul E. Harbaugh (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State May 4, 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Mol4/4 12525 Bradbury Ave. Smithsburg, Maryland 21783 AUIS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Demontia Due to (or as a consequence of): Cerchiovarinter accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibited events Due to (or as a consequence of). resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and (itle 29c. License number 29d. Date signed (Month, Day, Year) 1/06 D0062W3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

		•	1 - For State Registrar	State of M	aryland /	•	artmen <i>rtificat</i>			and M		giene Reg. No. 🤈 (006	1556	
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic	al	John G. Irons 4a. Facility Name (If not institution, giv	n atmost and number			Ab Cib	Town	Location of	of Dogsth	5	10 Cour	06 nty of Death		VI
£	Examin	ier	PENINSULA REGIONAL	Madian	Make		4b. City,	10WII, 01	04/564	12			Vicomi	-	
	Funeral			ex 7. Ag	e (In yrs. last	birthday)	If Under		If Under		8. Date of Birt	h Vaarl	9. Birth	place (State or Foreign	gn
	Director		104-24-81/3	² 82		Yrs.	Months	Days	Hours	Min.	(Month, Da 2-27-1	924	Cou	PA.	
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	ocation				w			10d. Inside City Limit	s
	Maryl f eho	ē	De. Sussex	r	La	ure1								XX Yes 2□N	0
	r 28a	Je C	10e. Street and Number				10f. Zip	Code				10g. Citizen o	of What Cou	ntry?	
	th with	a D	102 Sycamore Lan	ne					19	956		US	A		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mentella Hygiene. Timportant: if tien 27 is marked other then "natural", or iteme 23a or 28a-f ehow eny injury or other treumatic event, I'm Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XXXX 2 1 If Yes, Give Year or Dates:	No		Was Deced If Yes, spec 1 \(\text{Yes} \)		spanic Ori n, Mexican Specity:	gin? (Spo n, Puerto	ecify Yes or No Rican, etc.)		ace - Amen lack, White, cify: Wh	etc.	
9	72 hou	ted	15. Decedent's E (Specify only highest gra	ducation		6a. Dece	dent's Usua kind of wo	al Occupa	ition	t of work	ina	16b. Kind of	Business/ir	ndustry	_
2121	giene.	Completed	Elementary/Secondary (0-12)	College (1-4or !	5+)	life.	chani	se retired,)	OF WORK		Tracto	r Co.		
and	d be file	Be	17. Father's Name (First, Middle, Last, Edwin Irons								(First, Middle, Irons			nown)	
2	should nd Me mark matic	ဥ	19a. Informant's Name/Relationship (Type, Print)	1	19b. Maili	ng Address	(Street a			Al Route Numbe				_
Σ	alth a		Mary Irons, Wife								rel, De				
Baltimore, Maryland 21215-0036	Pages 1 a nent of He not: If item iry or othe		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		come	etery, cre	osition (Nar matory or c emoria	ther place			Date 5	20c. Location Bradfo1	•		
Balti	permit. Depertrimports eny inju		21. Signature of Funeral Service Lice	nsee	ر س	Ha		ın Sh	ort I	Disha	aroon Fo		Home,	Inc.	
1	Physician /Medical		23a. Part1. Enter the disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	aA	ne.	ubdu	ter the mod	le of dying	, such as	cardiac o	or respiratory ar	rest.	2010	Approximate Interval Between Onset and Death	
	death certificate be executed to the second	ical Examiner	Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Cue to (or sw	a consequent		d for	.\1						(wk	_
O.	ch the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 Fetal de	ath 3[□Ectopic pr □ Other (sp					1	Date of deliver	ery Day Year	
	w requires that s been signed by should be deta	۵	Part II. Other significant conditions of	contributing to death b	out not resultin	g in the u	nderlying o	ause give	n in Part I.			es 2 140		he cause of death?	'n
မ	ha ha	Completed										an 24b sy rmed? 2 No		opsy findings availab impletion of cause of	
/ita	certificate	Be	25. Was case referred to medical examiner?	(lessie) e				l au		of Death	(Check only o	ne)			
5	Physician: this certific ral director,	2	1 ☐Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie		Outpatier b. Time o		-	4 🗀 140		me 5 Resid			(y)	
o	Hing After Tune	盲	1 □ Natural 5 □ Pending 2 ☑ Accident investigatio	(Month, Da	y Year)	Injury	M	8c. Injury Work 1 □ Y	.? ′es 2.1 <u>√</u> 1	/	growind				
/isi	Attending r death. ector: After by the fune	= Ea	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	jury - At home					-	28f. Location (S	Street and Nur		al Route Number.	_
á	s efte	Certification:	4 Homicide	howe	tc. (Specity)					Į.	City or Tow 30416 Syl		ane,	Lamel DE	
	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best niner: On the basis o and manner st	f examination	dge, deat and/or in	h occurred vestigation	at the tim	e, date an	d place,	and due to the	cause(s) and r	nanner as s	tated.	-
	To the vithir To the Comp	ž	29b. Signature and title of certifier				290	. License	number			29d. Date sign		Dey. Year)	_
)	mil		(Jul				1	4504	97			5/1/06			
*	IVA		30. Name and address of person who Chris Snyder	completed cause of completed cause of completed cause of completed cause of complete cause of completed cause of cause of completed cause of	death (Item 23 Carro	la) (Type.	Print)	Sali	sbur	4,	mD	2180	1		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistr	rar's Signature	A	parti	,		•					

	State of Maryland / Department of Health and I Certificate of Death		Reg. No.	5555
Bhysician	Decedent's Name (First, Middle, Last)	2. Dete of Dee Month		3. Time of Death
Physician /Medical	Ursula Jankunas	May 11	2006	11:45 A.M.
Examiner	4a Fecility Neme (If not institution, give street end number) St. Vincent Care Center Emmitsb		4c. County of Deet Frederi	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		hplece (State or Foreign untry)
Director	215-54-3108 1 M 2 F 93 Yrs. Months Days Hours Min.	Dec. 1		ryland
pu *_	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
If I I I I I I I I I I I I I I I I I I	MD Frederick Emmitsburg			1 ∑Yes 2 No
ith the Mar or 28a-f sl be notified Director	10e. Street end Number 10f. Zip Code		10g. Citizen of What Co	untry?
th with	335 South Seton Avenue 21727		U.S.A.	
r theme 230 direc must	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
urs afte	11∑ Never Married 2 ☐ Married 1 ☐ Yes 22≦ No If Yes, Give 1 ☐ Yes 22≦ No Specify: Year or Dates:		Specify:	
thour street seed to	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind of Business/	ite Industry
ed within 72 ho tygiane. or than *natur. it, the Medical. Completed.	(Specify only highest grede completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	rking T	Religious C	
yd with ygiane critha	College 5+ Teacher		Daughters o	
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should be and marked umarked	Anthony Jankunas Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Re	Layman	r City or Town, State, 2	7in Code)
od 2 sho ith and 27 is m	Sister Camilla Harant 333 S. Seton Avenue,			1727
Deficiency in the system of th	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	
Pages nent of int: if the iry or o		3/06	EMMITSBURG,	MD. 21727
permit. Page Department of Important: If eny injury or price.			NERAL HOME	
88888	John M. Skiles 210 W. MAIN ST.,	EMMITSB	URG, MD. 21	.727
	23a. Pert1 Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock or heart failure. List only one cause on each line.	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final	+	1	/ /
Examiner	disease or condition resulting in death) e.	icha-	• 1	1 nous
Je Je	Due to (or as a tonsequence of):	Milan		10mms
cata be executed physician and sthe burial-transit adical Examiner	Sequentially list conditions, Due to (or any consequence of):	90000		- ()
Sian all	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlyin, Cause (Disease or injury			30yes
The law requires that the death certificate be executed ate has been signed by the attending physician and paga 2 should be detached for use as the burial-trinsit Completed by Physician/Medical Examin	that initiated events resulting in death) Last		1	0
eath certifical eath certifical eath certifical eath certifical eath of for use as the control of the control o	d			
at the death cert by the attendin etached for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	obacco uee contribute	to the cause of death?
tha of the trache trache	Tat in State significant conditions of the state of the s		/	obably 4 Unknown
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, paga 2 should be detached it Medical Certification: To Be Completed by Physic				
The law require tas been signated as should Completed		24a. Was a perfor	med?	Were autopsy findings available prior to completion of cause
law i law i has b a 2 st				of death?
i: The		1 🗆 Y		I □ Yes 2 □ No
sician cartifi lirector	examiner?	ath (Check only or	ne) ence 6 □Other (Spe	rifu)
Phys arthis erald	27. Menger of Death 28e. Dete of Injury 28b. Time of 28c. Injury at		ow injury occurred	July)
tal or Attending P is after death. at Director: After ted in by the funers Certification:	2 Accident investigation M 1 Yes 2 No			
r Atte ter de irecto	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Town	treet and Number or Run, Stete)	iral Route Number,
S are		.=11.4		
n 24 hound n 24 hound ne Funer pletely fil	29a. Certifier (Check only one) 1			
Vithin Vithin Co the comple	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Monti	n, Day, Year)
FSFO	DISTO	5	5/12/	06
1	30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)			
	ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, M	1D. 21727		
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's Signature			

DHMH 16 Rev 6/95

ORIGINAL

			For State Registrar		State o	f Marylar		artment of tificate o			lental Hy	giene Reg. No	Z II II 6	155	66
∜ Ph	ysicia	ın.	1. Decedent's Name (Sarah Ka			son					2. Date of De Month	Da		3. Time of D	
	Medic	al -	4a. Facility Name (If n					4b. City, Town	, or Loca	tion of Death	April	27	2006 County of Dea		РМ
5 \$.amm		Union Ho	spital				Elk	ton				Cecil		
	eral	1	5. Social Security Num 217-50-3		Sex 1□M 2□F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Day		nder 24 Hrs. urs Min.	8. Date of Bi	ay, Year,	9. Bir Co	hplace (State or I	DE
Dire	ctor	⊢	Usual Residence of D	7 7 7	AA	88					03-15	-18	Sum	mit Brid	igë,
arylan show	ie k	_		0b. County		10c. Ci	ty, Town or Lo							10d. Inside City	
the Mi	ctiffe	ecto	MD 10e. Street and Numb		cil		Che	sapeak		ity		10- 0	**	1 Yes 2	NO
ath with	mat be	6	268 Bethe					2	1915				U.S.A.	•	
21215-0036 d within 72 hours after death with the Maryland giene. er than "naturel", or Items 23a or 28a-f show	Expirition	Ď	11. Marital Status1 Never Married3 Widowed 4 		12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	odent Ever in U rces? 2No e X X ates:		Was Decedent of Yes, specify Ci		c Origin? (Spe ixican, Puerto ecify:	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: W		
5-0 72 ho	dical	Completed		5. Decedent's E only highest gr	ducation ade completed)		(Give	lent's Usual Occ kind of work dor	ne durina	most of works	na	16b. K	(ind of Business	Industry	
within had no within	N W	d d	Elementary/Second		College (1	-4or 5+)	life. L	DO NOT use reti	ired)		9	Dor	maati	/On one II -	
of filed withing the filed withing the filed withing other than	aut,#		12 17. Father's Name (Fil	rst, Middle, Last	")			Homemal		Mother's Name	(First, Middle			Own Ho	me
Maryland d 2 should be file th and Mental Hy T is marked oth	tic ev	To Be	Harry F.	. Cave	nder				F	loren	ce Mu	rray	7		
laryla 2 should and Men is marks	витов		19a. Informant's Nam	e/Relationship	Type, Print)		19b. Mailin	g Address (Stre					or Town, State, 2	Zip Code)	
e, N t and tealth in 27	or other traumatic event, the M	-	Florence 20a. Method of Dispos	John	son/Dau	ghter	P. O.	Вох 4	12,	Chesa	peake	Cit	MD tion - City or	21915	
Pages Pages nent of h	0 10 /		%∑ Burial 2 🔲 🤇	Cremation 3	Removal from	State	anielery, cren	ratory or other p	nace)	1		# 100 L			
Baltimore, permit. Pages 1 an Department of Heal Important: If item?	uniu		4 ☐Donation 5 21. Signature of Fune		•	ве	22	Cemeter Name and Add	fress of F	acility				ke City,	MD
X FFE	any BDCs		Rom	CA!	X (0.7.		D/ 21	NIELS &	HUI	CHISON	FUNERA	T HO	OME	100	
			23a. Part1. Enter the shock, or heart f	disease, or com ailure. List only	plications that cone cause	aused the deat	h. Do not ente	er the mode of d	ying, suc	h as cardiac o	or respiratory a	rrest,	DE 197	Approximate Interval Betwe	en
Physic	_		Immediate Cause (Fir disease or condition	nal	. a	es:	>15							On at and De	ath /
/Med Exam	11.5		resulting in death)	(Due to	onas a consec	uence of):	71						124	
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cuted	ransit	Examiner	if any, leading to immicause. Enter Underly Cause (Disease or injuthat initiated events	_	o. IV	seck	ed (recu.	13/9	US 1	ulce	N		ncek	5
8760, ate be executed hysician and	urial-t		resulting in death) Las	st .	Due to	or as a conseq	ruence of):	('C)	1	one				SPAY	~
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VISION Of VITAI RECONDS, P.O. BOX 68760, Attending Physician: The law requires that the death certificate be executed in death. •ctor: After this certificate has been signed by the attending physician and	d for use a		IF FEMALE: 23b. Was decedent pr in the past 12 mo 1 □ Yes 2 □ ✓	petis?	4☐Pregn.	irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregnar Other (specify)					23d. Date of deli Month	very Day Yea	ar
at the	etache	hys	9 🗌 Unknown		9□ Unkno										
dS, Fires that signed	eg .	<u>ה</u>	Part II. Other significa	int conditions	contributing to de	ath but not res	ulting in the un	derlying cause of	given in P	art I.			^	the cause of dea	
v requir	should	eted	1019	Cy U	EVVII C	· VC	101.				1 🗆 '	Yes 2		bably 4 Uni	
Rec ne taw ne taw	CI	Completed									24a. Was autor		24b. Were au prior to death?	topsy findings ava ompletion of caus	ailable se of
Vital Fician: The certificate	5	a)	25. Was case referred	to medical					26.5	Place of Donth	1 ☐ Yes (Check only o	2 V No		2 No	
of Vi Physicia this cer	direct	10 B	examiner? 1 Tes 2 No		Hospital:	Tpatient 2	ER/Outpatient	3□ DOA C	lab a				6 ☐Other (Spec	ufy)	
Division of Vital Records, for Attending Physician: The law requires that death. Director: After this certificate has been signe	ınərai		27. Manner of Death	5 🗌 Pending	28a. Date of	f Injury h, Day Year)	28b. Time of Injury	28c. Inj			28d. Describe I				
ISIO Itendi death.	the fu	cat	2 Accident	investigatio					☐ Yes						
DIV Il or A after Direc	d in by	Certification:	4 Homicide	determined	buildir	or injury - At no ig, etc. (Specif	y)	et, factory, office	е	2	City or Tox	Street an vn, State	nd Number or Ru n)	ral Route Numbe	<i>r</i> ,
DIVISION TO the Hospital or Attention 24 hours after deatly to the Funeral Director:			29a. Certifier (Check only 2[one)	Certifying Ph Medical Exar	nysician: To the miner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at the estigation, in my	time, dat opinion,	e and place, a death occurre	and due to the ad at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s)	
To th To th	comp		29b. Signature and the	o de destitiste	11111	110		29c. Licei	nse numb	рөг		29d. Dai	te signed (Month	Day, Year)	
^	10) (ff	41/1/1	1/1/VN			DY	51	55		05	101/2	006	
Ms.	. 0		30. Name and address												
Jan Star	Stat	0	John R. 31. Date filed (Month,	Mulve Day, Year)		111 V		h Stre	et,	Elkto	on, MD	2	1921		
Re	gistra	_	1		2 2006	ha	An	1- "							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

d PartIIperMil, 502 Maryland Department of Health and Mental Hygiene

ť	,		1- For Amend PartIIpe State RegistraMEND#23a,perMD	State of Mary 1MD, 5/2/06, DES, Mo	and / Depa DPS , Moco Ce / Ce /	artment of H	ealth and Death	Mental Hygie	ene 1. No.2 () () ()	15567
	Physic	an	1. Decedent's Name (First, Middle, Last)		T3 6776.0			2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		MAE ELIZZ 4a. Facility Name (If not institution, give s	ABETH	JACKSO	N 4b. City, Town, or	Location of Deat		22, 2006 4c. County of Death	10:20A M
	EXAIIII	iei	Prince Georges			Chev			Prince G	e or ge s
***	, Funeral Director		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp Cour 932 Was	lace (State or Foreign try) h DC
	pu .		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation	`			
	Maryla	tor	MD Prince			iverdal	e		'	0d. Inside City Limits 1 No 2 No
	with the	i Director	10e. Street and Number 6003 67th Ave			10f. Zip Code	0737	10g	Citizen of What Cour	itry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or iteme 23a or 28e-f ehow amy injury or other treumatic event, I're Madical Examiner must be notified at energy injury or other treumatic event, I're Madical Examiner must be notified at energy injury or other treumatic event.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	- 1	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: Bla	etc.
21215-0036	72 hou nature	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occupa	ation	16	b. Kind of Business/Inc	dustry
121	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	IN.	MD Univer	sitv
d 2	Hygie other	Be Co	8th 17. Father's Name (First, Middle, Last)		Foo	d Servi		er ne (First, Middle, Ma		
/lan	Wental Wental wrked	To B	William E.	Lee			Ha	rriett A	armstead	
Baltimore, Maryland	and la an		19a. Informant's Name/Relationship (Ty)	•					City or Town, State, Zip	
e,	1 and Health		Eugene Jackson 20a. Method of Disposition		b. Place of Dispos	sition (Name of		-	e, MD 20	
ē	Pages nent of h ent: If its ury or of		1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren	natory or other place 01n Cem	1		3rentwood	
alti	prmit. P spartme sporten y injury		21 Signature of Funeral Service License						neral Ho	
	20 E 2 3		Jesuft.	Sender					ckville,	MD20850
	Physician /Medical Examiner	er	23a. Part1. Enter the discusse, or complishook, or heart fall re. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):				cular Disca	Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and s the burial-transit	edicai Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of);					
	I he law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1□Live birth 2□F 4□Pregnant at time 9□Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, P.	furres thet n signed by	by	Part II. Other significant conditions con Hypertension	tributing to death but not	resulting in the un	derlying cause give	n in Part I.		co use contribute to the	a cause of death?
Vital Records,	The faw requir te has been s bage 2 should	Completed						24a. Was an autopsy performed	prior to con	sy findings available apletion of cause of
/ita	yetcian: The ils certificate ha director, page	Bec	25. Was case referred to medical examiner?	111			26. Place of Dea	1 ☐ Yes 2 ☑ th Check only one	NO LITES	2131NO
	this co	2	1 ☐ Yes 2 No		2 ER/Outpatient	3□ DOA Othe	r. 4 🗌 Nursing H	ome 5 Residenc	e 6 Other (Specify	
Division of	Attending Physician: r death. sector: After this certifice by the funeral director;	cations	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe how i	injury occurred	
É	Nospital or Atten 24 hours etter deatl Funeral Director: etely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre ecify)	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	To the Hospital or Attending Privilla Within 24 hours elter death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one) 1) Certifying Phys 2 Medical Examin	ician: To the best of my er: On the basis of exam and manner stated.	knowled e, death nination and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occur	und to the causerred at the time, date	e(s) and manner as eta and place, and due to	lted. the cause(s)
)	vithin 2 To the complet	Σ	29b. Signature and title of Sertifies	Such	•	29c. License			Date signed (Month, D	
	2		30. Name and address of person who con New Presson	npteted cause of death (-1/	Print) DC V4	Cha	rest-1 mr	4-22-	
	Sta		31. Date filed (Month, Day, Year) MAY 19 20	32. Hegistrar's Si	gnature	reles		()		

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Michael J. Klutch 2006 1:05 April 30 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 64 May 30, 1941 New York 060-34-4305 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Count or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28s-1 ehow any jury or other traumatic event, it is Medical Examination in the notified at once. 1 ☐ Yes 2 X No Director Gaithersburg Montgomery 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 20878 United States 1032 West Side Drive Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐ Yes 2 X No If Yes. Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Food and Drug College (1-4or 5+) Elementary/Secondary (0-12) Biologist Administration 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anne Yurowsky Harry Klutch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1032 West Side Drive, Gaithersburg, MD 20878 Margaret Klutch / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2006 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State May 3, Gate of Heaven Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, $10\ \text{East}$ 21. Signature of Funeral Service Licensee IRAG Huve Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonao 201 SV **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 s 1 ☐ Yes 26 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address of person who omplet 9901 Medica reiu 31. Date filed (Month, Day, Year) Registrar's Signature State 03 MAY 2006 Registrar

		1	For State of N		rtment of Health and tificate of Death		iene200	6 15569				
			I. Decedent's Name (First, Middle, Last)			2. Date of Deat Month		3. Time of Death				
	Physicia		Henry J. Klein			May 2,		5:10A ^M				
	/Medic Examin		a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or Location of De	eath	4c. County of	Death				
			Morningside House		Ellicott City	leo la a comunicación de la comu	Howard	Distribution (Obstance Consistence)				
	Funeral	- 1	1 🗓 M 2 🗆 F	Age (In yrs. last birthday) 82 ^{Yrs.}		Ain. (Month, Day	; Year)	. Birthplace (State or Foreign Country) ennsylvania				
	Director		89-12-4415 Usual Residence of Decedent	82		May 6,	1923	emisyivamia				
	ow s		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits				
	Man)	io.	Maryland Howard	Ellicott (City			1 ☐ Yes 2X No				
	th the	lrec	10e. Street and Number		10f. Zip Code		log. Citizen of Wha	at Country?				
	23e c	Funeral Director	5330 Dorsey Hall Drive #33		21042		USA	American Indian,				
	tems	nue	11. Marital Status 12. Was Decede Armed Force	s?	Was Decedent of Hispanic Origin' f Yes, specify Cuban, Mexican, P	ento Rican, etc.)		Black, White, etc. Specify: White				
36	s afte	by F	1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Date	s: WWTT	1 ☐ Yes 2 📆 No Specify:		Specify:					
ခု	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show than "neturel", or Items ra Madical Exercit er mait be notified at	edt	15. Decedent's Education	16a. Dece	tent's Usual Occupation	working	16b. Kind of Busin					
212	nin 72 in "ne Madik	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4c)	life.	kind of work done during most of DO NOT use retired)	WOIKING						
21.	giene er the	Completed	12	Instr	ument Mechanic		Oil Refi	nery				
nd	d oth	Be (17. Father's Name (First, Middle, Last)				e (First, Middle, Maiden Surname)					
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "neturel, or Items 23e or 28e-f show is marked other than "neturel, or Items 23e or 28e-f show to unatic event, It a Medical Externity at matter notified at	은	Louis Klein	10h Maili	Ceceliang Address (Street and Number o		r City or Town, St	ate. Zin Code)				
Maryland 21215-0036	12 sh h and 7 is n treun		19a. Informant's Name/Relationship (Type, Print) Robert Klein/son		Round Hill Rd.							
	1 and Healt em 2		20a. Method of Disposition			May 4,	20c. Location - Ci					
nor	ages ant of t: if it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	110			Beltsvil	le, Maryland				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked eny injury or other treumatic e <u>000.0</u>		21. Signature of Funeral/Service Licensee		2. Name and Address of Facility oing Home Crema							
ä	Depar Impo eny ir		Devel I Health	MO1251 B	everly L. Heckr	otte. P.A.	Clarksv	ille, MD 21029				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
ı	Physician /Medical Examiner		fmmediate Cause (Final disease or condition a. Squamous Cell Carcinoma									
			resulting in death) Due to (or									
	LAGITILICI	<u>_</u>		ed Dementia								
	ted	nine	cause. Enter Underlying Cause (Disease or injury									
_,	axecu al-trai	Examiner	that initiated events c.	as a consequence of):								
3760,	cate be executed physician and the burial-transit	Icai	d									
9	tificat ng phy as th		IS SENALS				-					
Вох	death certific e attending p id for use as l	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. ff yes, outco			23d. Date of delivery Month Day Year						
		Physician/Med	1 Yes 2 No 4 Pregnar 9 Unknown									
P.0	t the		Part If. Other significant conditions contributing to dea	th but not resulting in the i	tobacco use contribute to the cause of death?							
ds,		d by		101	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown							
ecords	law requires as been sign 2 should be	Completed			24a. Was an autopsy findings availat prior to completion of cause of death? ☐ Yes 2 □ No							
α	The lavate has	dmo		perfo								
Vital	ectificat rector, pa	a	25. Was case referred to medical	f Death Check onl o	th Check and one							
Σ	S 20 0	To B	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Ins	patient 2 ER/Outpatie	nt 3□ DOA Other: 4□ Nurs	ing Home 5 Resid						
n of		1.0	27. Manner of Death 1 ▼Natural 5 □ Pending 28a. Date of (Month,	Injury 28b. Time (Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		now injury occurred					
sio	Attending r death.	cati	2 Accident investigation		28f. Location (Street and Number or Rural Route Number,							
Division	or Attendation of the control of the country of the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place o building		City or Town, State)							
	ours a		29a. Certifier 1X Certifying Physician: To the b	est of my knowledge, dea	th occurred at the time, date and	place, and due to the	cause(s) and man	ner as stated.				
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in E	edical	(Check only 2 Medical Examiner: On the bas	is of examination and/or i	nvestigation, in my opinion, death	occurred at the time,	date and place, ar	nd due to the cause(s)				
	ro the vithin ro the complex c	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed	(Month, Day, Year)				
)			1 SI Chang		D50870		May 2, 2	2006				
1	2		30. Name and address of person who completed cause	of death (Item 23a) (Type	o, Print)	MD 21020						
<u> </u>	<i></i>		Suzan Abdo, M.D. 5005 Si	gnal Bell La Atrar's Signature	me ClarksVIIIe,	, FID 21029						
	St Regist	ate trar		low &	Sparte							
	3.3		MITTI O L		7							

		State of Maryland / D	epartment of Health and Mental F	•	5 15570					
4 -		Decedent's Name (First, Middle, Last)	2. Date of		3. Time of Death					
Phys	ician dical	Norma J. Klein	Month May	2 2006	12:35 P ^M					
	niner	4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dee						
		Howard County General Hospital	Columbia	Howard						
Funer Directo		1/2 30 /693 66	nday) If Under 1 Year If Under 24 Hrs. 8. Date of (Month, Trs.) Months Days Hours Min. Dec	Day, Year) C	thplace (State or Foreign ountry) nnsylvania					
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits					
Aaryla f sho	5		ott City		1 ☐ Yes 2 🛣 No					
the 1	Je Ct	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?					
3a oi		9213 West Stayman Drive	21042	United S	tates					
deatl	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Whi						
IIIG Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland all bygiene. d other than "natural", or items 23s or 28s-f show svent, tra Medical Examinar missiban cultified at	y Fu	1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	Specify:						
hours a tural; o	ed by	3 Widowed 4 Divorced Year or Dates:	Decedent's Usual Occupation	16b. Kind of Business	White					
in 72	olete	(Specify only highest grade completed)	Jecedem's Osual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business	Andustry					
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othe vent,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mid-	dle, Maiden Sumame)						
should b nd Menta marked	10	John Krutko	Elizabeth Bind)						
2 4 4 4		4	Mailing Address (Street and Number or Rural Route Null 13 West Stayman Drive Elli							
item 27		20a. Method of Disposition 20b. Place of 1	Disposition (Name of Date , crematory or other place)	20c. Location - City or						
Page nent c ant: If			Lawn Mem. Gard. 5-5-2006	Marriotts	ville, MD					
permit. Pages 1 a Department of He Important: If item any injury or othe	once.	21. Signature of Funeral Service Licensee M01044	22. Name and Address of Facility Harry H. 4112 Old Columbia Pike El		-					
Physicia	ın		ot enter the mode of dying, such as cardiac or respirator tory Distress Syndrome	y arrest,	Approximate Interval Between Onset and Death 8 days					
/Medica Examine		resulting in death) Due to (or as e consequence of Pneumonia		8 days						
uted I	Examiner									
fou, te be executed ysician and te burial-transit	cal Exa									
oo/ ificate g phys		d								
The COLORS, F.O. BOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year						
w requires that I been signed by should be detailed.	þ	Part II. Other significant conditions contributing to death but not resulting in Deep Vein Thrombosis		d tobacco use contribute to						
law requires as been sign	etec									
	Completed	Arterial Thrombosis		topsy prior to death?	utopsy findings available completion of cause of 2 ₩ No					
VICAL Iclan: 1 Sertificat ector, p	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check on	ly one)						
	on: To	X Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)								
Attending r death.	catl	2 Accident investigation								
LIVISION tel or Attending is after death. el Director: Afte	Certification:	4 Homicide determined 28e. Place of Injury · At home, fame building, etc. (Specify)	n (Street and Number or Ri Town, State)	Street and Number or Rural Route Number, vn, State)						
LIVISION To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due to to for investigation, in my opinion, death occurred at the time	he cause(s) and manner as le, date and place, and due	s stated. to the cause(s)					
To the within To the comp	×	29b. Signature and title of certifier	29d. Date signed (Month, Day, Year)							
		berses med 1	May 3, 200	ay 3, 2006						
2		30. Name and address of person who completed cause of death (Item 23a) (T			10.					
		10724 Little Patuxent Parkway Colum 31. Date filed (Month, Day, Year) 32. Wistrar's Signature	mbia, MD 21044							
	State istrar	MAY 0 4 2006	Grant ,							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) MAY 3, 2006 Year **Physician** MILDRED KUNZE 202 AM Ι. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBOT TALBOT HOSPICE HOUSE EASTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR. 18, 1911 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours Months 1 □ M 2 ₩ F 95 MARYLAND 220-01-0768 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State or 28a-f show traumatic event, the Medical Examinar must be notified at EASTON MD. TALBOT Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 610 DUTCHMANS LANE 21601 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural" apportent: other traumatic average. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER AUTOMOTIVE -0-18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be IDA PINDER PERRY LEE WHITBY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12576 OLD SKIPTON ROAD, CORDOVA, MD. 21625 FRANCES R. MORRIS / SISTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a Method of Disposition WOODLAWN MEM. PARK **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-5-06 EASTON, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. Joseph 200S. HARRISON STREEET, EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final poxerru Physician x daus disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ pe 1 Yes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed CONSCIOUSINESS 1□ Yes 2□No 1 Yes 2 No Hospital or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1-05 P100 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in 3y the f r death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier summen us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wild Avenue, caston, NO 2160 egistrar's Signature State 2006 Registrar

	1	For State Registrar		State of	Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	ealth a Death	and M	lental Hy	giene	06	15572
W 1 , 2 , .		1. Decedent's Name (First, Middle, Last)							2. Date of Death Month Day Year 3. Time of Death					
Physicia /Medica		HOWARD O.	KELLE	R							APRIL		2006	1640 M
Examine	- 60	4a. Facility Name (If not inst	itution, give	1.1			4b. City,		Location				y of Death	
		+HE MEMO			DITAL			,,	5101				ALB	OT
Funeral Director		5. Social Security Number 225–30–0521		x 7.]M 2□F	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Bir Month, Da DEC 2	Year 1925	9. Birthr	place (State or Foreign htty)
and and	-	Usual Residence of Decede 10a. State 10b. Co			10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
Many f sho	ō	MD	TALB	en T		ST.	MICHA	PT.S						Yes 2 No
the	Director	10e. Street and Number	TEXTLE			011	10f. Zip					10g. Citizen of	What Cour	ntrv?
3a of		203 SEYMOUR AVE.							663				USA	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, it a Medical Examil ar market incilling at	by Fur	11. Marital Status 1 Never Married 2 3 Widowed 4 Dive	Married	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? □ X io	W	f Yes, spec 1 ☐ Yes	Mo No	n, Mexicar Specify:	gin? (Spen	ecify Yes or No Rican, etc.)	Spec.		etc. I TE
Baltimore, Maryland 21215-0036 bermit. Pages I and 2 should be filed within 72 hours all beardment of Health and Mental Hygiene. mportant: If Item 27 Is marked other than "natural", or nny injury or other traumatic event, Ite Medical Event	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)					dent's Usua kind of wo DO NOT us SULTA	rk done d se retired	luring mos	t of worki	ng	16b. Kind of I	usiness/in	dustry
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lary 2 shou and N Is mar		19a. Informant's Name/Rela	ationship (Ty	(pe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	I Route Numb	er, City or Town	, State, Zip	Code)
Te, Ma 1 and 2 Health a Health a tem 27 ls	1	ANNIE Z. KEI	LLER/W	IIFE		PO	BOX 6	04 S	T. M	CHAI	ILS, MD	21663		
of He of He rothy		20a. Method of Disposition	a¥15	2	1 -	Place of Dispo			9)	C	Date	20c. Location	- City or To	own, State
Page Page Int: If		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth				T HÁVE				5/6/	2006	HARRIS	ONBUR	G, VA
Baltimore permit. Pages t Department of t Important: if its any injury or ot once.		21. Signature of Funeral Se			.f.5.P							NAM FUN ON, MD		HOME PA
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Geath certif	Me	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ונ		n 2 ∐ Feta tat time of d	Ideath 3□	Ectopic pr Other (sp						ate of delive	ory Day Year
	2	Part II. Other significant co	nditions cor	ntributing to deat	h but not res	ulting in the ur	nderlying ca	ause give	n in Part I.			obacco use cor Yes 2□No		ne cause of death? ably 4 □Unknown
Il Records, P.O. The law requires that the rate has been signed by the page 2 should be detached.	Completed										24a. Was autor perfo	osy ormed2	prior to cor death?	psy findings available inpletion of cause of 2 No
/ita	o n	25. Was case referred to me examiner?	_	Janeite I.	T T			of Death	h (Check only one)					
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		P Latshmi	van	ayanas	ham	11/1	/	y 0	5	114	17	APRIL	30	2006
10-		30. Name and address of pe												
10		LAKSHMI VAII	TANAY	1 44			HINGT	ON S	T EAS	TON,	MD 210	601		
Stat Registra	e r	31. Date filed (Month, Day, MAY 0	2006	A CONTRACTOR OF THE PARTY OF TH	istrar's Signa	ture	(h)							

			1 - For State Registrar	State of I	Marylan		artment rtificate			and M		g. No.	06	15573
	Physici	an	1. Decedent's Name (First, Middle								Date of Death Month	Day	Yeer	3. Time of Death
	/Medic	al	SARAH C.B. 4a. Facility Name (If not institution		ar)		4h City	Town or	Location of	of Death	APRIL	22 4c Count	2006 ty of Death	4:00PM ^M
	Examin	ier	WILLIAM HILL		517		45. Oily,		ASTON			40. 00011	TALE	ROT
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,	Voerl		ace (State or Foreign
	Director		210-03-9463	1 □ M 2 XX	94	Yrs.	Months	Days	Hours	Min.	SEPT 2	1911	PA	(y)
	and w	1	Usual Residence of Decedent 10a. State 10b. County	,	10c. Cit	y, Town or Lo	cation						10	Od. Inside City Limits
	Maryla F sho	ō		вот		WITT								1 ☐ Yes 2 X No
	the N	Director	10e. Street and Number	IDO I		MITI	10f. Zip	Code			10	g. Citizen of	What Count	try?
	3e or		9511 NEW ROAD	1				2167	6				USA	
	hours after death with the Maryland tural, or Items 23e or 28e-f show al Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede	nt Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		ice - America	
36	or Ite	y Fu	1 Never Married 2 Mar	1/1/ 0:			1□ Yes 2		Specify:	,,	7110411, 010.7	Speci		
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Maryland		To B	JOHN M. BULL	OCK						ELI	A C. MUS	SER		
lan	d 2 should th and Mer 7 le marke treumatic		19a, Informant's Name/Relations	_		19b. Mailir	ng Address	(Street a	and Numbe	or Rura	al Route Number,	City or Town	n, State, Zip	Code)
	s 1 and f Health item 27 other tr		MARY C. LYNCH	/DAUGHTER	20h E	Place of Dispo			WITT	-	MD 2167		City of Toy	- State
Baltimore,	9°= 5		20a. Method of Disposition 1 Durial 2 Cremation		to C	emetery, crei	matory or ot	her place					· City or Tov	
Ħ			4 □ Donation 5 □ Other (S21. Signature of Funeral Service		CIL					-	/23/2006			
Bal	permit. Departiments any injury		JOHN R	MERC	ERO		ELLOWS 00 S.	HAR	ELFEN RISON	BEIN ST	& NEWNA EASTON,	M FUNI MD 210	ERAL H 601	OME PA
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ita	iicien: Th certificate rector, pag	Be C	25. Was case referred to medica examiner?	à!					26. Place	of Death	(Check only one	_		
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n	ding Ph h. After th funeral	on:	27. Manner of Death 1 □ Natural 5 □ Pendii	ilg.	njury Day Year)	28b. Time or Injury		3c. Injury Work		- 1	28d. Describe how	v injury occu	rred	
sio	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 2							196 Location (Str.		has as Rosal	Davida Alizaba a	
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1	Hospita 4 hours Funerel	edical Co											ted. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certific		1 1	<u> </u>	29c.	License	number		29	d. Date sign	ed (Month, D	lay, Year)
)	->-0		> Intella	sun Xen	bod 1	MI)	DE	18	715		4/2	23/1)	4
	0		30. Name and address of person	who completed cause	of death (Item	(3a) (Type,	Print)	- 0				. /	10	U
	· d-		WILLIAM H. WO	OD, JR, M.D	. 501	DUTCH	IANS L	ANE,	EAS	TON,	MD 2160	1		
	Sta Regista		31. Date filed (Month, Day, Year, APR 2 5 20		istrar's Signa	iture	20							

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Mary	·	artment of rtificate or			giene	15574
1	N 71 gr		Decedent's Name (First, Middle, Last	st)				2. Date of De	aath	3. Time of Death
	Physici /Medic		Robert Albert K	eily				April	26, 2006 Yea	8:00 P M
	Examir		4a. Facility Name (If not institution, give				or Location of D		4c. County of De	eath
ir.				alth Can		1	30wre		Prince	beorge's
	Funeral		5. Social Security Number 6. S	Ctay 20 E	yrs. last birthday,	If Under 1 Yea Months Day		Min. (Month, Da	nth 9. B	irthplace (State or Foreign Country)
1	Director		Usual Residence of Decedent	-X	69 Yrs.			Feb. 1	9, 1937	L <u>A</u>
	land		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Mary	ğ	MD Prince (Georges	Bowie					1 X Yes 2 ☐ No
	r 28s	rec	10e. Street and Number			10f. Zip Code)		10g. Citizen of What	Country?
	h with	0	15410 Annapolis	Road		20715	5		USA	
	deat	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of	f Hispanic Origin	? (Specify Yes or No uerto Rican, etc.)	14. Race - An	nerican Indian,
9	or Ite	F	1X Never Married 2☐ Marned	1 ☐ Yes 217 No		1 Yes 2 N		dello ricali, etc.,	Black, Wi Specify: W	
21215-0036	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:						
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7	withir Bne. than	E C	Elementary/Secondary (0-12)	College (1-4or 5+)	Law		180)		Self-Emplo	avo d
о 5	Hygid Hygid Sther	ပိ	17. Father's Name (First, Middle, Last)		Law	yeı	18. Mother's	Name (First, Middle		byed
au	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itema 23s or 28s-f show marked other than "natural", or itema 23s or 28s-f show imatic event, the Medical Exercites.	To Be	Lawrence Mary Ker	11 y			Hild	a Ann Brev	wer	
Maryland	should be fand Mental Is marked of	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ng Address (Stree	et and Number o	r Rural Route Numb	er, City or Town, State	, Zip Code)
Š	alth a		John Keily/ nephe	ew .	154	10 Annap	olis Ro	ad Bowie	, MD 20715	
J'e	of He of He item		20a. Method of Disposition		Db. Place of Disponent	osition (Name of matory or other p	lace)	Date	20c. Location - City of	or Town, State
Ĕ	Page nent c int: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	Huntt Cr			/30/2006	Waldorf,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f show says injury or other treumatic event, the Medical Examinating the notified at 2008.		21. Signature of Funeral Service Licen	\$ 99	2	2. Name and Add	ress of Facility	Robert E.	. Evans Fur	neral Home
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	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions or	ontributing to death but no	t resulting in the u	inderlying cause g	given in Part I.		obacco use contribute Yes 2 □ No 3 □ F	to the cause of death? Probebly 4——Unknown
l Records,	The law re ate has be page 2 sho	Completed							psy prior to ormed? death?	autopsy findings available completion of cause of
<u>i</u> ta	cien: ertific actor,	Be	25. Was case referred to medical examiner?	All Control of the Co				Death Check only		
5	hysi this c	은	P_ 165 Z_ NO		2 ER/Outpatie	nt 3 DOA	ther: 4 Nursin		dence 6 ☐ Other (Sp	ecify)
Ĕ	ling F	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	W		28d. Describe i	how injury occurred	
S	Attending Physicien: r death. sctor: After this certification the funeral director.	cat	2 Accident investigation 3 Suicide 6 Could not be		At home form at]Yes 2 □No	20f Location (Street and Number or F	2 / D / - N
Division of Vital	lor A after Direct	Certification:	4 ☐ Homicide determined	building, etc. (Sp	pecify)	геет, тадоту, опто	Ð	City or Tox		Hurai Houte Number,
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my iner: On the basis of exal and manner stated.	knowledge, deat	h occurred at the vestigation, in my	time, date and pl	ace, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier		-		nse number	1	29d. Date signed (Mor	nth, Day, Year)
			Jaraon,	front Di		17	60055 F	27	April :	28, 2006
			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	touss's	,	April :	
			Situador Silves	the same of the sa	ting of the	Drin	مع م	my 1	un /un	
*	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 1	32. Registrar's S	ignature	book		7	,	

	*		1 - For State Registrar	State of M	aryland /		rtment tificate			and M	ental H	ygien Reg. N	200	16	15	575
	Physici /Medic		Decedent's Name (First, Middle, La. SCOTT DAVID								2. Date of D Month APRIL		Ž006	Yeer	3. Time of 21:45	
	Examin		4a. Facility Name (If not institution, giv. 10275 MILL HOLLOV	LANE			CH	ESTE	Location o	N		40	County of KENT	-		
ŀ	Funeral Director		5. Social Security Number 218-58-7620 6. S Usual Residence of Decedent	ex 7. Aç ☑ M 2□ F	ge (In yrs. last bi	Yrs.	If Under Months	Days Days	If Under a		8. Date of B Month, D MARCH	irth Day, Year 6, I	953	9. Birthp	place (State ntry) MD	or Foreign
	Maryland e-f show	ctor	10a. State 10b. County MD KENT		10c. City, Tow										1 Yes	City Limits
	th with the 23e or 28	Funeral Director	10e. Street and Number 10275 MILL HOLLO	W LANE			10f. Zip (Code 2162	0			10g. C	itizen of W USA		ntry?	
9036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-1 show eny injury or other treumetic event. If a Medical Evertime russi be notified at once.	b	11. Marital Status 1 □ Never Married 2凶 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 □ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. No	1	Vas Decede Yes, speci		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	lo-		, White,		
21215-0036	ad within 72 h giene. er then "nett I've Medice.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or		(Give l	ent's Usual kind of work OO NOT use RANCE	done di retired)	uring most	of workir	ng	16b. F	Cind of Bus	siness/In URAN		
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	and 2 sho ealth and m 27 is m her treum		19a. Informant's Name/Relationship (ANN LIVIE/WIFE	Гурв, Print)		1027	5 MIL	L HC		ROAI	Poute Num CHE	STER'	TOWN,	MD	21620	
Baltimore,	. Pages 1 Iment of H tent: If ite jury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	<i>(</i>)	20b. Place of cemete SHREW	sy, cren SBUR	atory or oth Y CEM	her place ETER	Y 0.	5/02,	/2006	CHE	ocation - C	OWN,	MD	
Ba	permit Depar Impor eny in		21. Signature of Funeral Service Licer	lefferle		F 1	ELLOW 30 SP	Address S H EER	of Facility ELFEI ROAD	NBEIN CHI	N AND ESTERT	NEWN.	AM FU MD 2	NERA 1620	L HOM	E
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DIX	itel or Attendersters after deathrel Director:	Certification:	3 Suicide 6 Could not be determined	building, et	c. (Specify)						8f. Location City or To	wn, State	9)			ıber,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	one) 2 Medical Exam	ysician: To the best liner: On the basis o and manner st	t examination ar	e, death nd/or inv	estigation, i	n my opi	nion, death	l place, a h occurre	nd due to the d at the time	date and	d place, an	d due to	the cause(s	:)
	7, 2 5 1 1 5 2	~	29b. Signature and title of cettifier	rint			1	License 2	SS S	7		57	te signed (6	Day, Year)	
1	4)		30. Name and address of person who amount of the state of	MD 6	leath (Item 23a) (O) (D) (ar's Signature	H)	RCH	HU	LRI	7 0	HCSTE	EVI	m	M	D 20	620
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			For State Registrar	State	of Maryla		artment of F			Reg. N	- 21111	6 15	576
	Physici /Medic		1. Decedent's Name (First, Middle Helen Lanni		istina	Helen	Lanni		2. Date Monti Apri	L 28		4:05	72.14
	Examir		4a. Fecility Name (If not institution Annapolis Nurs: 5. Sociel Security Number		ehab. C	enter		r Location of Annapo	olis	of Birth		e Arund	
e e	Funeral Director		158-03-1819 Usual Residence of Decedent	1□ M 2√F	89	Yrs.	Months Days	Hours	Min. (Mont	h, Day, Yea 17,		irthplace (State Country) New Jer	sey
	th the Marylan or 28a-f ehow e nutified at	lirector	10e. Street and Number	Ocean	10c. C	ity, Town or Lo	Mantol 10f. Zip Code	oking		10g. C	citizen of What (City Limits
336	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other than "natural", or items 23e or 28e-f ehow imalic event, the Madical Examinar must be notified as	by Funeral Director	304 North Bay I 11. Marital Status 1 □ Never Married 2 □ Marr 32. Widowed 4 □ Divorced	12. Was Dec Armed F	XXNo ive	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	08736 ispanic Origi an, Mexican, Specify:		or No-	U.S 14. Race - Am Black, Wh Specify:	erican Indian,	
21215-0036	ed within 72 hou giene. er than "naturs er the Medical E.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	st grade completed,	1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired DMEMaker	ation during most o	of working	16b.	Kind of Busines Own H		
aryland 2121	should be filed ind Mental Hygid marked other umatic event, II	To Be (17. Father's Name (First, Middle, Biaggio Moscat 19a. Informant's Name/Relations	ciello		10b Maili	ng Address (Street	Ant	s Name (First, Moinette	Izzon	е	Zin Codol	
≥	d 2 in the air		Anthony Lanni, 20a. Method of Disposition 1 Burial 2 Cremation	/son	State	304 N Place of Dispo cemetery, cree	North Bay osition (Name of matory or other place	Drive		oking	, New Je Location City of	ersey 0	3736
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 Donation 5 Other (S	pecify)	St	22	s Cemeter Name and Addres To Duke of	ss of Facility	/3/2006 John M. cester S	Taylo	ewood, l or Fune nnapolie	ral Home	∋
	Physician was provided with principle of the purial-transit the burial-transit the purial-transit the principle of the princi	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	caused the dealer line. (or as a consector as a consec	quence of):	er the mode of dyin	A .			Dusan	Approxima Interval Be Onset and	tween
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Division of Vital	ding Phys	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manney of Death 1 Natural 5 Pendin investit 2 Accident investit 3 Suicide 6 Could referred to medical medical medical medical solutions.	Hospital: 1 ☐ 28a. Date (Mor	of Injury oth, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work M 1 🗆	er: 4 🗔 Nurs	>	Residence ribe how inju	ury occurred		
DIX	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide determ	ined 289. Flact build	ing, etc. (Spec	fy)	reet, factory, office		City o	r Town, Stat			ber,
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	Sta	te	PAU A. 1 31. Date filed (Month, Day, Year)) = VOR	egistrar's Sign	1203(WEEN-	SBUR	grat	1791	Tsonke	Molo	181
	Registr	ar	MAY 0	1 2006	Separa .	B. A	and s						

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Blazina J.S.

			For State	State of Marylar	nd / Departi		ith and M	ental Hygie		15578
			Registrar	1	0071111	10010 01 20	407	2. Date of Death	. 140.	3. Time of Death
	Physici /Medic		1. Decedent's Name (First, Middle, Last SOPHIE	, MO9K	OW			APRIL.	29,200	6 7:55 AM
	Examin	er	4a. Facility Name (If not institution, give Hebrew Home of Gre	ater Washing	ton	Rockvi	ille		4c. County of De	ry
	Funeral Director		117-32-2040	x 7. Age (<i>In yr</i> s			Under 24 Hrs. Jours Min.	8. Date of Birth 03/07/79419	(9 as) 9. 8	Birthplace (State or Foreign Country) LOWA
	D >		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Location	on				10d. Inside City Limits
	a-f shov	ctor	Md. Montgome		ockville					1 ☐Yes 2 ☐ No
	th the	ire	10e. Street and Number		1	10f. Zip Code		10g	. Citizen of Whal	Country?
	15 wil	alD	6121 Montrose Rd			20852			US	
	dea	ner	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13. Was	Decedent of Hispar es, specify Cuban, M	nic Origin? (Spe fexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - A	merican Indian, hite, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury por other traumatic event, Ira Medical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Yes 28 No Si			Specify:	white
0	72 ho	ted	15. Decedent's Ed (Specify only highest grad		16a. Decedent	's Usual Occupation	n na most of workir	16	b. Kind of Busine	ss/Industry
21	thin thin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	Hor	d of work done durin NOT use retired) nemaker			Own	Home
S	ad w	S	12							- ITOMIC
p	al Hy	Be	17. Father's Name (First, Middle, Last)			18.		(First, Middle, Ma	uden Sumame)	
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	nd 2 should be filed within 7 alth and Mental Hygiene. 27 is marked other then "! ir traumatic event, I'm Med		19a Informant's Name/Relationship (7 Lenore Moskowit	ype, Print) z/Daughter	19b. Mailing A 11708	ddress (Street and Caplinge:	Number or Rura r Rd. Si	<i>Route Number, C</i> Llver Spr	city or Town, State cing, Md.	20904
Baltimore,	nt of Her		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition cometery, cremator	ory or other place)			c. Location - City	
Ħ	ther tant dury		* 4 □ Donation 5 □ Other (Specify			orial Gar			Olney, M	
Bal	Departiment of the service of the se		21. Signature of Funeral Service Licen	111	117	ame and Address of Danzar O Rockvil	lle Pike	Rockvi	lle, MD	hapels 20852
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a conse	ARY IAL equence of): EDEM	ENTIF	D 15 E.B. 7	ASE		Approximate Interval Between Onset and Death
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cor	aw requir s been si 2 should	piete						24a. Was an autopsy		aulopsy findings available to completion of cause of
æ	The lav	Eo						performe	d? death	
ta		0	25. Was case referred to medical			26	. Place of Death	(Check only one)		
<u>></u>	ysicism: is certific director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2[☐ ER/Outpatient	3□ DOA Other:	4 Wursing Hor	ne 5 Residen	ce 6 Other (S	pecify)
0	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	2	28d. Describe how	injury occurred	
Division of Vital Records,	r Attending Physician: er death. rector: Atter this certific by the funeral director,	Certification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		home, farm, street,	M 1 Tes	2 🗆 No	28f. Location (Stre City or Town,		Rural Route Number,
Q	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the			ysician: To the best of my ki						
	the H in 24 the F plete	Medical	one)	and manner stated.						
	To the within 2 Complet	Σ	29b. Signature and title of certifief by working the control of the control of the certifier of the certifi	e Kolori	my M.D	29c. License nu D 35	436	14	Date signed (Mo	29, 2006
	2		30. Name and address of person who	completed cause of death (It	em 23a) (Type, Pri	ONTROSI	5 ROAD	RECKI	ILLE H	D20856
	St	ate	31. Date filed (Month, Day, Year)	32 Aegistrar's Sig	nature	le				il

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** APRIL 24 2006 1:30AM M VIRGINIA M. MICHEAL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21601 TALBOT 14 CURZON COURT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 21, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1926 1□M 2**X**F Months Days Hours MARYLAND 79 Vrs 219-20-5285 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show if item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Evanting must be notified at 1 Yes 2 No EASTON Director MD TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14 CURZON COURT 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: Ď 3X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE 0 PATIENT ACCTS. SUPERVISOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental H PAULINE KEENE LLOYD GIFFORD ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 1522 MCGINNIS POND ROAD, MAGNOLIA, DE 19962 VICTORIA D. SUMMERS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State WOODLAWN MEMORIAL PARK 4/28/2006 EASTON, MARYLAND 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERON 200 S. HARRISON ST EASTON, MD 21601 MHOK R 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Canas Onset and Death Immediate Cause (Final Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially is conditional if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 II Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 **N**0 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has rmed? 2 ₩ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month) Day, Year) 29b. Signatu 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State



Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death Month I. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** THOMAS FREDERICK MACKIN, JR. 6:07 APRIL 14 2006 \mathbf{P}^{M} /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CHESAPEAKE HOSPICE HOUSE LINTHICUM ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. Director 128-14-7901 NY Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 27 is marked other then "natural", or items 23e or 28e-f show treumetic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director MD QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 224 OYSTER COVE DRIVE 21638 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1943— If Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ğ 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced 1945 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) be tiled within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 INSURANCE BROKER 4 INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be ti and Mental H 7 is markad otl Be THOMAS F. MACKIN, SR. ELIZABETH CARRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health ar ELIZABETH MACKIN/WIFE 224 OYSTER COVE DRIVE, GRASONVILLE, MD 21638 permit. Pages 1 and Department of Healt Important: If itam 2' any injury or other i 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State CROWNSVILLE VETERANS CEMETERY 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 04/19/2006 CROWNSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 1)04 disease or condition resulting in death) /Medical Due to (or as a conse ur nce of): Examiner Sequentially issue and tensify any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certiticate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, physician ian/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ó Month Day Year 4☐Pregnant at time of death Physici 5 Other (specify) P.O. the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2[] No Division of Vital 1 Yes 2/2 No ☐ Yes To tha Hospitel or Attanding Physician: 25. Was case referred to medical LASE CHISAGEARC 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Cother (Specify) HOPILE 1 ☐ Yes 2 ☑ No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sales.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ame and address of mpleted cause of death (Item 23a) (Twoe, Print) tNA Pous 449 149 Ci 31. Date filed (Month, Day, Year) Black & Spark Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of M	certificate of	Dooth	
	_	Decedent's Name (First, Middle, Last)	Certificate of	2. Date of Deeth	s. No.
	Physician	GLENWOOD R. MAT	MILENC	Month	Day Year
	/Medical	4a Facility Name (If not institution, give street and number		April 4b. City, Town, or Location of Death	28, 2006 3:15 Am
4	Examiner	Cherry Lane Nursing C		Laurel	Anne Arundel
	Function		ge (In vrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8. Date of Birth	
	Funeral Director	216-12-4787 ★₩ ^{2□ F}	84 Yrs. Months Days	Hours Min. (Month, Day, Y	,1921 Maryland
		Usual Residence of Decedent			
	rylen thow	10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	r 28a-f show	Md Anne Arundel	Laurel		1 XYes 2 No
	or 2	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?
	death with the Marylend one 23e or 28e-f show from the multiple at meral Director	3504 Spring Rd,	2072		U.S.A.
		11. Marital Status 12. Was Deceden Armed Forces	t Ever in U,S. 13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	urs after	1 Never Married 2 Married 1 2 Yes 2 ☐ If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	I TRITAL ZIINO	Specify:	Specify: Black
8	within 72 hours aftar ane. than "natural", or its be Medical Examine ompleted by Fu	15. Decedent's Education	1942-45	netion 16	BLACK Bb. Kind of Business/Industry
5	led within 72 hoi ygiane. Per than "natura nt, the Medical In Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working d)	b. Kind of Business industry
12		Elementary/Secondary (0-12) College (1-4or 7th Grade	Custodian	_	J.S. Agriculture
D	生工を 2 の	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Ma	iden Surname)
Maryland 21215-0036	should be ad Mental marked o matic eve	John Matthews		Carvella (Cromwell
ary	shot send N is main	19a. Informant's Name/Relationship (Type, Print)		and Number or Rural Route Number, C	City or Town, State, Zip Code)
	D \$ 1. 5	Douglas Powell (Step-		ng Rd, Laurel,	Md #20724
ore	of Heal of Heal r other	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other pla	ce) Date 20	c. Location - City or Town, State
Ē	Pag ury o	4 □ Donation 5 □ Other (Specify)	Mt Zion Church	Cem. $5/1/06$ 1	Laurel, Md
Baltimore,	permit. Pages Depertment of Important: if it any injury or ance.	21. Signature of Funeral Service Licensee	22. Name and Addre	•	3 20050
ш	9Q = # 9	Troll K, Dury	Snowden 346 N W	Funeral Home P.	.A. 20850 Rockville, Md
		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	nd the death. Do not enter the mode of dyin	ng, such as cardiac or respiratory arrest	t, Approximate Interval Between
	Physician				Onset and Death
4	/Medical Examiner	Immediate Cause (Final disease or condition HYPER	TENSIVE CARDIOVA	SCULAR DISEASE	Many Yrs.
		resulting in death)	Due to (or as a consequence of):		_
	ficeta ba executed physician and is the burial-transit edical Examiner	b			j I
	ificeta ba executed g physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):		9 9
68760,	physician the buria	cause. Enter Underlying Cause (Disease or injury that initiated events	Down to form the control of the cont		
289		resulting in death) Last	Due to (or as a consequence of):		
Box	attending for usa a	d			
	death d for	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause give	ven in Part I 23b. Did tobe	ecco use contribute to the cause of death?
P.0	as that tha death cerigned by the attendine be datached for use by Physician/N	Demonstra Channel		1 □ Yes	2 No 3 Probably 4 Unknown
	as tha igned be da	Dementia, Chronic	Jostructive Pulme	onary	
pro	v requiras that tha death cert been signed by the attendin should be datached for usa leted by Physiclan/N	Disease, Chronic A	nemia	24a. Was an a	d? available prior to
900		Discussive Children	ichtu.		completion of cause of death?
æ	The I			1 ☐ Yes	2∰No 1 ☐ Yes 2 ☐ No
Vital Records,	sician: The law certificate has t lirector, page 2 s	25. Was case referred to medical examiner?		26. Place of Death (Check only one)	
£	는 양양 는	1 ☐ Yes No Hospital: 1 ☐ Inpat	ient 2 ER/Outpatient 3 DOA	Nursing Home 5 Hesidence	
n c	and feel no	27. Manner of Death 12 Natural 13 □ Pending (Month, Discourse)			injury occurred
Sic	deeth.	2 Accident investigation 3 Suicide 6 Could not be		Yes 2 □ No	et and Number or Rural Route Number,
Division of	tal or Attending P rs after death. at Director: After t led in by the funers Certification:	determined 200. Flace of II	ijury - At home, farm, street, factory, office fc. (Specify)	City or Town, S	
	poltai ours filled filled C	29a. Certifier XXCertifying Physician: To the best	of my knowledge, death occurred at the tir	me date and place, and due to the caus	se(s) end manner es stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the It Medical Certificati	(Check only one) 2 Medical Examiner: On the besis of and manner s	of examination end/or investigation, in my of	ppinion, death occurred at the time, date	and place, end due to the cause(s)
	Neithin To the Sompl	29b. Signature and title of certifier	29c. Licens	se number 29d	Date signed (Month, Day, Year)
		H Booker	D-2:	3181	May 1, 2006
	,	30. Name and address of person who completed cause of			, -, -oo
	6	R.G. Bhojraj M.D.	5632 Annapolis Ro	d, #10 Bladensh	ura, Md 20710
	State	31. Date filed (Month, Day, Year) 32. Regist	rer's Signature		

DHMH 16 Rev 6/95

			For State	State of Ma	aryland / Depa	artment of I <i>rtificate of</i>							
			Registrar				Dealii	2. Date of Deal	eg. No.	3. Time of Death			
	Physici	an	1. Decedent's Name (First, Middle, Lasi	Mitc	1,011			Month	Day Year				
	/Medi	1.60	4a. Facility Name (If not institution, give		Nevi	4b. City, Town,	or Location of Death		4c. County of De				
	Examir	ier	Atlantic General			Berlin			Worcest	er			
	Funeral	477	5. Social Security Number 6. Se	7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	9. B	irthplace (State or Foreign Country)			
	Director		143-44-6100]м 2 % F	56 Yrs.	Months Days	Hours Will.	4/2/1950		ÑĴ			
3	pu ,		Usual Residence of Decedent 10a. State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits			
	with the Maryland a or 28e-1 ehow be notified at	-								1 AYes 2 No			
	Ne M	Director	MD Worcest	er	Ocean	10f. Zip Code		1	0g. Citizen of What 0	Country?			
	with th	D.	10e. Street and Number	20		21842		'	USA	Southly :			
	sath w	era	414 Lark Lane #10	12. Was Decedent	Ever in U.S. 13		Hispanic Origin? (Spe	ecify Yes or No-		nerican Indian,			
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturet", or items 23s or 28e-f show event, the Mudical Exeminer must be notified at	by Funeral	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2XXI If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Spe an, Mexican, Puerto Specity:	Rican, etc.)	Black, Wh Specify: Wh				
9	72 hours "naturel",	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occu	pation during most of works	ina	16b. Kind of Busines	s/Industry			
215	hin 7 9. Bn "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	i+) life.	DO NOT use retire	ed)	nig.					
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pu		Be	17. Father's Name (First, Middle, Last)				18. Mother's Name						
yla	Men Marke Marke	2	John Marko	0.4-1)	405 54-11	A dd /Cara	01ga (no			Zin Code)			
Maryland 21215-0036	d 2 should be filed within 72 hour th and Mental Hyglene. ?7 is marked other than "nature! fraumetic event, the Madical Ex		19a. Informant's Name/Relationship (7 Eric M. Mitchell	ype, Pnnt)					ty, Md. 21				
	1 and Healt em 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of			20c. Location - City of				
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke eny injury or other traumetic. once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Sunset M		Park 5-3-		Berlin, N				
Ball	permit. Departimport import eny inj		21. Signature of Funeral Service Licen	Bulage			am St., Be		e Funeral d. 21811	ноте			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	est,	Approximate Interval Between								
	Physician		tmmediate Cause (Final disease or condition	Lung	Cancer	_				Onset and Death			
A.A.	/Medical		resulting in death) Due to (or as a consequence of):										
100	Examiner	_	Sequentially list conditions, if any leading to immediate Brain Metusters Due to (or as a consequence of):										
	cuted	amlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence or):								
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687	ficate p phys	edlo		d									
.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use es the burial-transit.	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	⊒Ectopic pregnanc ☐ Other (specify)	су		23d. Date of d Month	lelivery Day Year			
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ta	an: rtifice tor, p	BeC	25. Was case referred to medical				26. Place of Deat		~ ()				
Į V	ysic lis ce direc	To B	examiner? 1 ☐ Yes 2 No	Hospitat:	ent 2 ER/Outpatie	nt 3 DOA	her: 4 Nursing Ho	me 5 Resid	ence 6 □Other (Sp	pecify)			
o uo	ding Ph th. : After the funeral	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	W	ory at ork? ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred				
Division	al or Attendi s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of th	ury - At home, farm, s c. (Specify)	treet, factory, office	,	28f. Location (S City or Tow	treet and Number or in, State)	Rural Route Number,			
	To the Hospital or Attend within 24 hours after death To the Eunerel Director: completely filled in by the	Medical C			of my knowledge, dea of examination and/or i ated.								
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier				ise number		29d. Date signed (Mo	nth, Day, Year)			
			I truck Gu	1	MD	DO	50636	41	May 1, 2	006			
- 7	- 1		30. Name and address of person who			, Print)	9733 Hea		,				

State

Registrar

Frank Guarnieri Atlantic General Horpital
31. Date filed (Month, Day, Year) | 32. Appistrar's Signature

MAY 0 3 2006

9733 Healthway Dr. Berlin MD 21811

Ame	ended	20	State of Maryland / Departr State of Maryland / Departr State of Maryland / Departr State of Maryland / Departr State of Maryland / Departr	ment of Health and Micate of Death	lental Hygie	2000	15584
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medi		John Calvin Newman		May 2,20		0007 M
	Examir			o. City, Town, or Location of Death		4c. County of Death	
	*		HOMOLIGE HOUPE	Easton Under 1 Year If Under 24 Hrs.	8. Date of Birth	Talbot	place (State or Foreign
	Funeral Director			onths Days Hours Min.	(Month, Day, Ye 03-03-192	ar) Cou	place (State or Foreign ntry)
	<u> </u>		Usual Residence of Decedent		03-03-172	4 Ia.	
	nylan		10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
	Ba-1 s	Directo	Maryland Caroline Greensbor				1 ☐ Yes 2 No
	ith th	Dire	10e. Street and Number	10f. Zip Code		Citizen of What Cou	intry?
	s 23e	erai	13880 Drapers Mill Road 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was	21639		USA 14. Race - Ameri	can Indian
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Never Married	Decedent of Hispanic Origin? (Spe es, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White	
036	urs af	by	3 Widowed 4 Divorced Year or Dates:	Yes 2☐(No Specify:		Specify: Wh	ite
5-0036	72 ho	Completed	15. Decedent's Education 16a. Decedent' (Specify only highest grade completed) (Give kind	's Usual Occupation d of work done during most of worki	no 16b	. Kind of Business/Ir	ndustry
	ithin	nple	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)	S	elf Emplo	•
121	filed within 72 hours after death with the Maryland Hygiene ither than "natural", or tems 23a or 28a-f show ither than "natural", or tems 23a or 28a-f show ont, I've Medical Exandrat must be footified at		12 Electr:	1	(First, Middle, Maid	Electrici	an
™ m	ntal H	Be			•	,	
n Newman Maryland 2121	should ind Men	٢	Lloyd Newman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing A	Olivett ddress (Street and Number or Rura			p Code)
Za Za	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show minportant: if item 27 is marked other than "natural", or items 23a or 28a-f show important in the recitied at any injury or other traumatic event, the Madical Exantinat must be recitied at Angles.			Drapers Mill Rd			
o h	s 1 ar f Hea item othe		20a. Method of Disposition 20b. Place of Disposition	on (Name of	ate 20c	. Location - City or T	
L E	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol C:	10370	4/2006 4 -2006 D	over,Dela	ware
Joh Baltimore,	rmit partrr ports y inju		21. Signature of Funeral Service Licensee 22. Na	ame and Address of Facility ennie Smith Fune			
8	897 2 8		4.	26 Dover Street,	Easton, M	aryland 2	1601
			23a. Part 1. Enter the decise, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition preumo Throad				Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	1.0	0 4		
À	Examine.	1	Sequentially list conditions, Due to (or as a consequence of):	tie pulvanar	y dise	Pese	yeurs
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): Two cuts Two cuts		U		40.
-	execunated and al-train	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):	<u>e</u>			pros.
760	ate be executed hysicien and the burial-transit	ical	d				
89	tificat ng phy as th						
Вох	es thet the death certifica igned by the attending pt be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetel death 3 □ Ect	opic pregnancy		23d. Date of deliv	,
	e dea the att	sici		her (specify)		Month	Day Year
P.O.	d by the that		Part II. Other significant conditions contributing to death but not resulting in the under	thing cause given in Rad I	22e Did tobaco	co use contribute to	the cause of death?
ls,	The law requires thet the death certifics are has been signed by the attending pt page 2 should be detached for use as it	þ	h es terrein	lying cause given in Farci.			bably 4 Dunknown
0.00	v requ been shouk	etec					
Rec	has pe 2 s	Completed	2) another		24a. Was an autopsy performed	? prior to co	opsy findings available impletion of cause of
a	iician: Th certificate rector, pag	e Co	25. Was case referred to medical	OC Blace of Dooth	1 Yes 2	No 1 □ Yes	2 No
==	Physician: r this certifica ral director, i	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death		6 □Other (Speci	(v)
0	ding Phys		27. Mannar of Death 28a. Date of Injury 28b. Time of		28d. Describe how in		
Ö	ath. or: Afr	atio	2 Accident investigation	M 1 Yes 2 No			
Division of Vital Records,	r Atter de lirecto	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
۵	oital ours af arai D						
	Hosp 24 ho Fune stely (Medical	29a. Certifier 1 ✓ Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or investigant manner stated.	curred at the time, date and place, a igation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	itated. o the cause(s)
	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Mec	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	F ≤ F ŏ		2 Monte is	64043	M	ay 2, 2	006
	b				C. 1	-	
	3-		PAUL W. Morte, NS 2195	". Goshington	4. 24	spy, M) 2/60/
7.	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 0 A 2006	NO.	/		

	1	For State Registrar		maryia ———	•	artment rtificate			-,	Reg. No. 20	106 1558
Physiciar /Medica Examine	n 11 -	Rosalie A. Nero A. Facility Name (If not institution, give		nber)		4b. City, T	own, or l	Location of Deat	2. Date of De Month	Day 25 c	of Death
		PENINSULA REGIONA	1 Med	tical	CONTO		54	rusbuy			icanics
Funeral Director		222-10-9072	M 2[XF	7. Age (In yr: 80	s. last birthday) Yrs.	If Under 1 Months	Year Days	Hours Min.	8. Date of Bin (Month, Da 7-27-1	th 19. Year) 925	9. Birthplace (State or Forei Country) De.
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or iteme 23s or 28s-f show ont. I've Medical Examinar must be notified at a Commission by Elimeral Directors.		Usual Residence of Decedent 10a. State 10b. County			City, Town or Lo	ocation					10d. Inside City Limi 1 ☐ Yes 2 🏋 N
vith th	5	10e. Street and Number	_			10f. Zip 0				10g. Citizen of W	
eath v	Funeral	9088 Woodland Fer	ry Rd. 12. Was Dece	dent Ever in	U.S. 13.	Was Decede		956 spanic Origin? (S	pecify Yes or No	USA - 14 Race	- American Indian,
ours after death with the Marylan rail; or iteme 23s or 28s-1 show Exercition matter notified at	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	rces? 2∭XNo e		if Yes, specif		, Mexican, Puèr Specity:	pecify Yes or No o Rican, etc.)	Specify:	c, White, etc.
be filed within 72 hours half Hygiene. of other then "natural", event, the Madical Exa	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1	-4or 5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupat done du retired)	tion uring most of wo	rking	16b. Kind of Bus	siness/Industry
ad wit	5	8			Hom	emake					Home
ed is p	o ne	17. Father's Name (First, Middle, Last) John Russell West						Cora Sc	ott West	Maiden Surname	
2 short and reum		19a. Informant's Name/Relationship (Ty								er, City or Town,	
C = 14 F	- 3-	Francis Nero, husb	and	20b.				The second secon	i. Laure.	1, De. 1	9956 City or Town, State
		XXBurial 2 Cremation 3 F	Removal from S	State	Place of Dispo cemetery, cred d Fello			4-29	0-06		
permit. Pages 1 a Depertment of Hes Important: if Itam eny injury or othe	Ī	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		ار م	→ Ha	Name and	Address 1 Sh	of Facility		Laurel,	ome, Inc.
Par par	cai Exar	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a F M							
ath cer ettendir for use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		inth 2 ☐ Fe ant at time of	tal death 3	∃Ectopic pred ☐ Other (spec				23d. Date Mon	e of delivery th Day Year
wrequires that the deben signed by the should be detached	2	Part II. Other significant conditions con	ntributing to de	eath but not re	esulting in the u	nderlying ca	use giver	n in Part I.			bute to the cause of death? 3 Probably 4 JUnknow
for Attending Physician: The law requires's lefter death. Director: After this certificate has been signs in by the funeral director, page 2 should be	Completed									osy promed? de	lere autopsy findings availab rior to completion of cause o eath? □ Yes 2□ No
ician certifi rector	CC CC	25. Was case referred to medical examiner?	Hospital:				Other	P1	ath (Check only o		
nding Physician: The la th. ** After this certificate he: a funeral director, page 2	tion: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	1 [2]	npatient 2 of Injury th, Day Year)	28b. Time of Injury		c. Injury Work	4 Nursing F		dence 6 Othe	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place buildir	of Injury - At ng, etc. (Spe	home, farm, st				28f. Location (\$ City or Tov		or or Rural Route Number,
Hospitel or 24 hours efter Funeral Dir	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	ner: On the ba	best of my k asis of exami ner stated.	nowledge, deat nation and/or in	h occurred at vestigation, i	t the time	e, date and place inion, death occu	, and due to the irred at the time,	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)
within 2 To the complet	Ž	29b. Signature and title of certifier	1	1		29c.	License	number		29d. Date signed	(Month, Day, Year)
, 1		30. Name and address of person who or	and U	e of death (It	em 23a) (Tune		06	2934		April 2	5 2006
Q M							r4.1	nd, 218	94		
		31. Date filed (Month, Day, Year)		21			11				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar	tificate of	Death		Reg. No 2	006 1558
Physici	an/	Decedent's Name (First, Middle, Last)			2. Date of De Month April 29,		3. Time of Death 1425 hrs
dical Exami	iner	Mary Bruce Mackall Prince 4a. Facility Name (if not institution, give street and number)		b. City, Town, or Location of		4c. County of	
		Anne Arundel Medical Center		Annapolis	Doutt	Anne Aru	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ast birthday)			Birth (MM/DD/ YYYY)	9. Birthplace (State or
Director		224-62-1676 1_M 2XF 94	Yrs	Months Days Hours	Min Oct.	23, 1911	Countwashington
any		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Locati	on			10d. Inside City Limits
* .			Annapol				1 Yes 2 XNo
Aaryland 28a-f show 1 at once.	ctor	Maryland Anne Arundel A	Milapoi	10f. Zip Code		10g. Citizen of Wha	at Country?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ten of Health and Mental Hygiene int: If item 27 is marked other than "natural", or items 23a or 28a-fisher other traumatic event, the Medical Examiner must be notified at once	Director	7105 River Crescent Drive		21401		United St	ates
n with ms 23 be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.s Armed Forces?		s Decedent of Hispanic Orig es, specify Cuban, Mexican,		No- 14. Race - White,	- American Indian, 8lack,
or ite	Fun	1 Yes 2 X No			, , , , , , , , , , , , , , , , , , , ,		
s after rral",	by	3 X Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)		Yes 2 X No specify: t's Usual Decupation (Give N	kind of work done	Specify 16b. Kind of 8us	White siness/Industry
2 hour	ted	Elementary/Secondary (0-12) College (1-4 or 5+)		ost of working life. DO NOT		100. Halla of Cao	and dody
5-0036 lled within 72 h Hygiene Jother than "r	Completed	4	Home	Maker		Own Ho	me
5-00 led wit Hygien other the Me	ပ္ပ	17. Father's Name (First, Middle, Last)			s Name (First, Middle		
2121 uld be fil Mental I marked	Be	Laidler Mackall			che Evelyn		
ID 21215-003 should be filed within and Mental Hygiene 7 is marked other the Medianic event, the Medianic event, the Medianic event, the Medianic event.	To	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Num 1rany Court			
, MD and 2 sho salth and em 27 is raumati		Marion Moore/ Daughter 20a. Method of Disposition 20b. F	1	ition (Name of cemetery,			City or Town, State
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		1 Burial 2 V Cremation 3 Removal from State	crematory or oth	ner place)	5/2/2006		od, Maryland
Baltimo permit Page Department of Important: injury or oth		4 Donation 5 Other Specify: FOT 21. Signature of Funeral Service Licensee		oln Cremator		T 1 T	1 17
Bal permi Depar Impo injur		Mile 12 Diam			John M.		Funeral Home olis, MD 21401
Physician		23a. Part I. Enter the disease, or complications that caused the death.	. Do not enter t	ne mode of dying, such as c	ardiac or respiratory a	arrest, shock, or hea	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Intercerebral Hemorrha)	ge				Death
Examiner		or condition resulting in death) Due to (or as a consequence of					
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	of).				_
	je.	cause. Enter Underlying Cause	1).				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	f):				
760, cate be executed physician and the burial - transi		dd					
760, cate be execut physician and he burial - tra	Medical		nanav			23d. Date of o	delivery
68760, certificate be nding physic se as the buri	Z N	IF FEMALE: 23b. Was decedent pregnant in the second 12 months? 23c. If yes, outcome of pregnant in the Live birth		tal death 3 Ectopic	c pregnancy	Month Month	Day Year
OX 68' eath certiff attending for use as	sician/	4 Pregnant at time of de	eath 5 Ot	her (Specify)			
W & S & S	Phys	Part II. Other significant conditions contributing to death but not re	ne ulting in the	underlying course given in Br	ort I 23e Die	tobacco use contrib	bute to the cause of death?
ires that the d signed by the	ğ	Part II. Other Significant conditions Contributing to death but not re	esulting in the t	andenying cause given in ra			Probably 4 Unknown
ords, law requires seen sign should be	ted	W				as an 124b. W	Vere autopsy findings available
law re has be	Completed				pe	formed? de	rior to completion of cause of eath?
tal Rec inn: The l certificate b	5			00 81		s 2 No 1	Yes 2 No
f Vital Physician: er this certifi ral director,	a	examiner? Hospital: 1 Innation: 2	EP/Outpatien	26.Place of Death Other	Nursing Home 5	Residence 6	Other:
	은	1 V Yes 2 No Impatient 2 V	28b. Time of	3 Jon 4		e how injury occurre	
- ± − √ 3	<u>ii</u>	1 V Natural 5 Pending (Month, Day, Year)		1 Yes 2	_		
Division fall or Attending a Ster death al Director:	<u> [</u>	2 Accident Investigation 28e. Place of Injury - At he	ome, farm, stre	et, factory, office building, et	tc. 28f. Location	(Street and Numbe	er or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)			or Town	, State)	
Div Hospital or 24 hours afte Funeral Dir		29a (entrer	ige, death occu	rred at the time, date and pla	ace, and due to the ca	ause(s) and manner	as started.
Division To the Hospital or Attent within 24 hours after death To the Euneral Director: completely filled in by the	Medical	one) Medical Examiner: On the basis of examination a and manner safted	and/or investiga	tion, in my opinion, death oc	ocurred at the time, da	te and place, and du	ue to the cause(s)
F 3 F 8	₹	29b, Signature and little of certifier		29c. License number			ed (Month, Day, Year)
		Jan IV		O.C.M.E.		April 30, 20	06
		30. Name and address of person who com, eted cause of death (Item			MD 0405:		
		Susan Hogan MD. Assistant Medical Examiner		nn Street, Baltimbre, I	MD 21201		
	State		ure	noth 1			
Regi	ગાહ	WITH A THE STATE OF THE STATE O	- July 100				

			For	State of	Maryla	nd / Depa					lental Hy	/giene		TEEO T
			1 - Stete Registrar			Cei	rtificat	e of L	Death			Reg. No.	.000	15587
	Physici	an	Decedent's Name (First, Middle, La	st)							2. Date of De Month	Day	2006	3. Time of Death 2:15 P
15. P 23.11	/Medio		Leroy L. Peake 4a. Facility Name (If not institution, give	a atroot and num	hasi		4h Cihr	Tourn	Location	of Dogsh	April	29	2006 County of Deat	
1	Examir	ier	Montgomery Gener		•		01ne		LUCATION	OI Dealli			Montgom	
No.	Funeral	100	5. Social Security Number 6. S			. last birthday)	If Under	-	If Under	24 Hrs.	8. Date of Bi			
	Director			⊠ M 2□F	84	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Da 3-20-19	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Was	hplace (State or Foreig untry) hington,DC
	yland now		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Mar Fied	to	MD Montgome	ry	Si	lver Sp	ring							MOXYes 2 □ No
	or 28;	irec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	untry?
	th wil	Funeral Director	3100 N. Leisure W	orld Bl	vd. Ap	t.503	209	06				U.	S.A.	
	eme	Iner	11. Marital Status	12. Was Dece Armed For		J.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
36	or it	y FL	1 Never Married 2 Married	1 ⊠Yes If Yes, Give	2 🗌 No		1 🗆 Yes				, , , , , ,		Specific	
Ö	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Modical Examiner mast be notified at	Completed by	3 Widowed 4 Divorced		tes: WWI		4 4 - 1 1					1 400 10	WII	ite
15	"nal	lete	15. Decedent's Ed (Specify only highest gra	ide completed)		16a. Deced	kind of wo DO NOT u	al Occupa rk done d	ition lu <i>ring</i> mos	t of worki	ng	16b. Ki	nd of Business/	Industry
12	withi ene. than	mo	Elementary/Secondary (0-12)	College (1-	4or 5+)		ract					Dep	t. of N	avv
D	filed Hyg other	BeC	17. Father's Name (First, Middle, Last,								(First, Middle			
lan	lid be lental ked ic ev	To B	Raphael Peake						I	Mary	Shock			
ary	shou and N e mai	_	19a. Informant's Name/Relationship (19b. Mailir	ng Address	(Street a	ind Numbe	er or Rura	I Route Numb	er, City or	Town, State, Z	Tip Code)20906
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or iteme 23s or 28s-f show many injury or other traumatic event, the Medical Examiner must be notified at ance.		Anita M. Peake/Wi	fe		3100	N. Le	eisur	e Wo	rld l	B1vd.#5	03 S	ilver S	pring,MD
Baltimore, Maryland 21215-0036	Tite of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from 9		Place of Dispo cemetery, crer	sition (Nar	ne of ther place	9)	С	Date	20c. Lo	cation - City or	Town, Slate
Ě	Pag ment ant: i		4 Donation 5 Other (Specify			dean Me				-3-0			y, MD	
Salt	epart epart nport ny inj		21. Signature of Funer I Service Licer	1500							_			irection
	0 □ = 0 0		23a. Part1. Enter the disease, or com										MD 208	552
Aij:	Physician /Medical Examiner	- a	snock, or near failure. List only Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any leading to immediate	a. Pe	or as a conse	Effu	slo pat	N					4,	Approximate Interval Between Onset and Death
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.O. Box 6	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		th 2 Fet int at time of	al death 3	Ectopic pr Other (sp					2	3d. Date of deli Month	very Day Year
S,	es tha igned be de		Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the ur	nderlying c	ause give	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
Records,	w require been si should b	Completed by	Ever Stude K	eval	W154	755					10	Yes 2[No 3SP	bably 4 Unknown
ec	as b	npie									24a. Was	psy	prior to c	topsy findings available completion of cause of
	ilcian: The lav certificate has rector, page 2	So									perfo	rmed?	death?	200
Vital	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:			- 7	Otha		of Death	Check only	оле)		
	Physician: r this certificaral director,	T.	1 Yes & No	28a. Date o		ER/Outpatien 28b. Time of			4 🗀 14u		ne 5 🗆 Resi		Other (Spec	erfy)
O	ding h. Afte fune	tion	Natural 5 Pending 2 Accident Investigation	(Month	, Day Year)	Injury	м	8c. Injury Work 1 □ Y	? 'es 2 □ !		LOG. Describe	now injury	occurred	
Division of	or Attend iffer death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place	of Injury - At h g, etc. (Speci	nome, farm, stre fy)					28f. Location (City or To			ral Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	dical Co	29a. Certifier Certifying Ph	inter: On the ba	sis of examin	owledge, death	occurred estigation	at the time	e, date an	d place, a	and due to the	cause(s)	and manner as	stated.
	thin 2 the other	Med	29b. Signature and title of certifier	and mann	er stated.			License					signed (Month	
	£₹¥8			MD			1	Nor	1521	69		i.J	129/	C
•	12		30. Name and Midress of person tho	completed cause	of death (Ite	m 23a) (Tyne	Print)	21	ارب			= !	10-170	6
***	Sta	•	Matthew Hr. M. 31. Date filed (Month, Day, Year)	drew	gistrar's Sign	01 Pr	YNCE	Ph	lip.	Dri	re C	1/n	by R	D 20836
	Registr		B B B B B B B B B	006	ENS 1	to do	alle						1	

		1 - For State Registrar			Marylaı	•			ealth and Death	Mental H	Reg. N	2006	15588
Physic /Medi		1. Decedent's Name (First John	R.			Palmer				2. Date of D Month April	30,	2006 Year	3. Time of Death P 11:28
Examination Funeral Director	ier	4a. Facility Name (If not in. 6984 Amber 5. Social Security Number 215-26-5262	Fields 6. Se	Court		. last birthday) Yrs.	Sa.	lisbu	Location of Dealery If Under 24 Hr Hours Mir	s. 8. Date of B		Wicomic 9. Bir	
g g	ctor		ent County Vicomic	20	10c. C	ity, Town or Lo alisbur				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Plan	10d. Inside City Limits 1 ☐ Yes 2 🖾 No
th with th 23s or 26	Funeral Director	10e. Street and Number 6984 Amber	Field	ls Court	:		1	0 Code 21804	1		10g. C	itizen of What Co USA	ountry?
Ind 21215-0036 be filed within 72 hours after death with the Maryland stal Hygiene. Ind other than "natural", or items 23s or 28s-1 show event, the Medical Evaninar must be notified at	by	11. Marital Status 1 Never Married 2(3 🖾 Widowed 4 Di	Married	12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Da	es? 2 □ No Art		Was Dece If Yes, spe 1 Yes	cify Cuba	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Wh	
1215-0 within 72 hc ane. than "natus	Be Completed	15. De (Specify only Elementary/Secondary (cation e completed) College (1-	4or 5+)	life.	kind of wo DO NOT u	ork done d se retired	furing most of w	orking		Kind of Business	
ed al ed 9	To Be Co	17. Father's Name (First, M John Palm	fiddle, Last)			POS	tmast	er		ime (First, Middle Ione Sh	e, Maide	n Sumame)	Service
e, Maryla 1 and 2 should Health and Mer 1 marke 1 marke 1 marke		19a. Informant's Name/Re Deborah P. 20a. Method of Disposition			er		4 Amb	oer E	nd Number or F		lis	or Town, State,	21804
Baltimore, I permit. Pages 1 and Department of Healt Important: if item 2 any injury or other page.		1 Signature of Funeral S	her (Specify))	tate	ishopvi	natory or o	Cemet Cemet and Addres Way E	ery 5/	3/06 Home Pro	B: ofess	ishopvil ishopvil sional A , MD 218	le, MD
Physician /Medical Examiner		23a. Part1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	e. List only or	a.	used the dea	sth. Do not ent		de of dying	g, such as cardia		arrest,		Approximate Interval Between Onset and Death
8760, ate be executed hysician and the burial-transit	icai Examiner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			r as a consec								
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregn. in the past 12 months 1 Yes 2 No 9 Unknown	HIII		th 2 ☐ Feta nt at time of d	al death 3[Ectopic p					23d. Date of del Month	ivery Day Year
cords, P w requires that been signed b should be deta	by	Part II. Other significant c	onditions cor	ntributing to dea	ith but not res	sulting in the u	nderlying o	ause give	n in Part I.			1.0	the cause of death?
	e Completed	25. Was case referred to n	nedical						00 Div	1 Tes	psy ormod2 2 1 No	prior to death?	utopsy findings available completion of cause of 2 No
of Vita Physician: this certifical	ToB	examiner? 1 Yes 2 No 27. Manner of Death				ER/Outpatier			^{IC} 4 ☐ Nursing I		idence	6 ☐Other (Spec	cify)
Vision of Attending Ph r death.	Certification:	1 Natural 5 2 Accident 3 Suicide 6	Pending nvestigation Could not be determined	28a. Date of (Month) 28e. Place of	if Injury - At h	28b. Time of Injury	М		at ? ′es 2 □ No	28d. Location	Street a	nd Number or Ru	oral Route Number,
Divisio To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi	edical Cert	29a. Certifier	rtifying Phys	Notant To the b	g, etc. (Speci	uwledae, Jest	vestigation	at the tim	e, date and plac	City or To	enticula) and manner as d place, and due	stated.
To the H within 24 To the F Complete	Medi	29b. Signature and title of		in A	or stated.	Cersed		c. License		2,110 (1110)		ite signed (Mant)	
JA		30. Name and address of Dr. Benjami	n H. M	eyer	400 E	Eastern		e Dr	ive, Sal	lisbury,	MD	21804	-
Sta Registi	-	31. Date filed (Month, Day,	Year) 2 20	32. Re	gistrar's Signa	ature	/ /						

DHMH 17 Rev 1/2001

		_ 1	For State Registrar	State of Maryland		tment of H ificate of L			giene Reg. No	006	15589
4			1. Decedent's Name (First, Middle, La					2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		HELEN PA	PPAS				MAY	1	2006	(DOD AM
1	Examin	50.	4a. Facility Name (If not institution, gi	1.		4b. City, Town, or				ounty of Death	MERY
		0		ENERAL HOSPITAL Sex 7. Age (In yrs. ias	at hirthday)	If Under 1 Year	JEY If Under 24 Hrs.	8 Date of Birt			place (State or Foreign
27.3	Funeral Director			Sex 7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Nov 1	y, Year) 0. 19:	Cour	nington, DC
			Usual Residence of Decedent								
	yland		10a. State 10b. County	10c. City,	Town or Loca	ation				1	1 ☐ Yes 2 🔼 No
	Ba-f s	cto	Maryland Montgo	omery Sil	ver Sp						
	or 26	Director	10e. Street and Number			10f. Zip Code	5602		10g. Citizer	n of What Cour	ntry?
	ath w		15100 Interlache	en Drive, #210 12. Was Decedent Ever in U.S.	12.18/	20906- as Decedent of Hi		pecify Yes or No	_ 14	USA Race - Americ	can Indian
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Madical Examinar must be notified at	by Fur	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If '	Yes, specify Cuba	Specify:	o Rican, etc.)		Black, White, DecifWhite	etc.
9-0	r2 ho	Completed	15. Decedent's l		16a. Decede	ent's Usual Occupa	ation Juring most of wor	k <i>i</i> na	16b. Kind	of Business/In	dustry
218	within 72 ene. than nat	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT use retired)		_		
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nd	ould be filed v I Mental Hygie varked other t vatic event, III	Be	17. Father's Name (First, Middle, Las Thomas Pappas	:1)				nia Mand		mamey	
Maryland	12 should be and Mental I is marked or raumatic even	ို	19a. Informant's Name/Relationship	(Type Print)	19b. Mailing	Address (Street a				own, State, Zir	c Code)
Ma	d 2 s. Ith an 27 ls i					Marlbrou					
ē	Heal Heal tem 2		Gus Pappas/ Bro	20b. Pla	ce of Disposi	ition (Name of atory or other place	1	Date		tion - City or To	
JOE	ont of	,	1 □XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Hemoval from State		L Cemeter	- may	7 4,	Suit	land, N	Maryland
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau		21. Signat (a) Funeral Service Lic	-Cole	F1 50		Collins	d, W, S	ilver	e Inc Sprinc	, MD 20901
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	CARD CARD	IDMYO	PATHY	g, such as cardiac	or respiratory a	11631,		Interval Between Onset and Death
	/Medical Examiner		1000 thing in doubly	Due to (or as a conseque	ence of):						
1/42		ا ق	Sequentially list conditions,	b. Due to (or as a conseque	ance of):						
	uted d ansit	dicai Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć,	cate be executed physician and the burial-transit	Еха	resulting in death) Last	Due to (or as a conseque	ence of):						
8760,	ite be iysicia ne bu	cai		d							
9	ng ph	0	IF FEMALE:	ST							
O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of deal 9 ☐ Unknown	death 3 □E	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
P.0	requires that the een signed by th nould be detache		Part II. Other significant conditions	contributing to death but not resul	ting in the uni	derlying cause giv	en in Part I.	23e. Did 1	tobacco use	contribute to t	the cause of death?
ds	w requires that s been signed to should be deta	d by						1 🗆	Yes 2 🗆	No 3∏ Prol	bably 4 Munknown
Records,	~ Q 70	Completed						24a. Was		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
<u>=</u>	: The faw cate has page 2 s	Con						1 ☐ Yes		1 🗆 Yes	2 🗆 No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		3C DOA Oth	ar	ath Check only		70 (0	
of		2	1 ☐ Yes 2 No 27. Manner of Death	1 Minpatient 2 LE	R/Outpatient 28b. Time of	30 000	4 Indiani	lome 5 Resi			(y)
o	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day Year)	Injury	28c. Injun Wor M 1 🗆	k? Yes 2□No				
Division of	or Atten after deal Director: in by the	ertifica	3 Suicide 6 Could not determine	t be Ose Blace of Injury. At hos	me, farm, stre	et, factory, office		28f. Location (City or To		Vumber or Rur	al Route Number,
_	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical Certification:	29a. Certifier 1 Certifying (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the best of my know teminer: On the basis of examination	rledge, death on and/or inv	occurred at the tir estigation, in my o	ne, date and place pinion, death occi	a, and due to the urred at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. to the cause(s)
	lo the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date :	signed (Month,	Day, Year)
	- 3-0		180Ata	- HOSPITALIST	-	DE	2656		MAY	1, 200	06
	2/		30. Name and address of person wh	no completed cause of death (Item	23a) (Type, F	Print)					
_	メク		SONIA HOLMES,		CE PHI	UP DRIL	E DIME	MD MD	2083	>2_	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2006 32. Registrar's Signatu		and a					

physicien and s the burial-transit P.O. Box 68760. as ettending p signed by the eld be detached for Records. has certificate Division of Vital After this funeral of death. Director:

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician Mae Marie Phebus MAY 2006 1:35A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Boonsboro Reeders Memorial Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X□ F 92 213-24-9137 Yrs 09/29/1913 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 US 212 Belview Avenue Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 0 1 ☐ Yes 2 X No Specify: White 3 → Widowed 4 Divorced netural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Annie Mary Earley Grover Cleveland Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11828 Wolfsville Road, Smithsburg, MD 21783 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Depertment of Health as Important: If Item 27 is any Injury or other trau Betty L. Harris / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/08/2006 | Hagerstown, MD Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cerebra proliable 141000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2/2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 5 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3251 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756 (301) 432-2222 ROBERT GUEDENET, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 0 5 2006 Registrar DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and M 1- For State Registrar Certificate of Death		iene _{eg. No.} 2006	15591
			Decedent's Name (First, Middle, Last)	2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic		Maria Esther Ricourt de los Santos	May 1,	2006	12:28a M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
			Suburban Hospital Bethesda 5 Social Security Number 6 Sax 7 Aga (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgon	
	Funeral Director		Months Days Hours Min.	(Month, Day, Jan. 20,	Year) Coun	lace (State or Foreign try)
			Usual Residence of Decedent	20,	1020 001211	
	yland how		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
	e Mar	ctor	Maryland Montgomery Bethesda			1 ☐ Yes 2 ☐ ¥No
	ith th	Director	10e. Street and Number 10f. Zip Code	10	0g. Citizen of What Cour	•
	filed within 72 hours after death with the Maryland Hygiene. the rhan "natural", or Itema 23e or 28e-f show ant, the Medical Examinat must be notified at	rai	4521 East-West Highway, Apt. 204 20814	- 14 - V - 2 - 2 - N -	USA 14. Race - Americ	
	ter de Item	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	Rican, etc.)	Black, White,	etc.
36	urs af	by F	3 ☐ Widowed 4 ☐ Provoced Year or Dates:	nican	Specify Black	
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working the completed)	70	16b. Kind of Business/Inc	dustry
216	thin 7 e.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working iffe. DO NOT use retired)	,g		
	ygien ygien rerth	Con	Restaurant Owner	(F: . AF 1 !!: A	Food	
pu	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last) Demetrio Ricourt 18. Mother's Name Ercil:		os Santos	
Maryland	hould d Mer mark matic	2	19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rura			Code)
Ma	od 2 s lith an 27 la	H	Agustina Ravelo de Santiago/ 8712 Briarcroft Lane, 1			
9	F Hear	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May	ate 6	20c. Location - City or To	wn, State
96	Page nt: 5		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 2006	•	Silver Sprin	g, Maryland
Baltimore.	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene Important: If Itam 27 is marked other than "natur any Injury oceaner traumatic avant, the Medical once.		21. Signature of Funeral Service Licensee Francis J. Collins I	Funeral	Home Inc.	
Ω.	88 = 88		500 University Blvd,			MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arre	est,	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death) Arrhythmia			Onset and Death
2	/Medical Examiner		Due to (or as a consequence of):			
0		P	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
Ö	uted J Insit	Examiner	cause. Enter Underlying Cause (Disease or injury			
ی م	exection and rial-tra		resulting in death) Last Due to (or as a consequence of):			
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75 89	ntifica ing ph	Med	IF FEMALE:			
★) 🦁	eath certific attending p for use as i	lan/l	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive Month	ry Dav Year
₹ o	he de the a	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)		,	
70	that the di	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?
F sp	quires n signi ald be	q pa		1 🗆 Ye	es 2□No 3□Prob	ably 4 ∰Unknown
\ <u>₹</u> 8	law requir as been s 2 should	Completed		24a. Was ar		osy findings available
	The ta	mo		autops perform 1 Yes 2	y prior to cor ned? death? 2 [™] No 1 □ Yes	npletion of cause of 2□ No
2 (Be C	25. Was case referred to medical examiner?			
2 2	9 v =	70	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Reside	nce 6 Other (Specify)
	ding Ph h. After th funeral	no U	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe ho	w injury occurred	
	tan leati tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be determined determined	Of Location /St	reet and Number or Rura	I Pouto Number
R1Cc Division	after d	Certification:	4 Homicide determined building, etc. (Specify)	City or Town		HOUSE NUMBER.
	To the Hospital or Attanding within 24 hours atter date for the Funeral Diractor: After completely filled in by the fune		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the ca	ause(s) and manner as st	ated.
	the Ho hin 24 t the Fu npletely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, da	ate and place, and due to	the cause(s)
	To the company	Σ	29b. Signature and title of gentifier 29c. License number	25	9d. Date signed (Month, I	Day, Year)
	2		1 Wylles 1002949		7/2/0	φ
	A		30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Ma	500 Old aryland	Georgetown	Road, Bethesd
1	Sta	to	THE TOTAL CONTRACTOR OF THE TOTAL CONTRACTOR OT THE TOTAL CONTRACTOR OF THE TOTAL CONTRACTOR OT THE TOTAL CONTRACTOR OF THE TO			
	Registi		31. Date filed (Month, Day, Year) MAY 0 3 2006 32. Degistrary Signature			

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** April 8:40 P 30 2006 Martha Rosmeisl /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 KF 68 March 29. 1938Czech Republic Director 148-36-4792 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo MD Cecil Chesapeake City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 310 Bunk Lane 21915 should be filed within 72 hours after death and Mental Hygiene. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Medical other than Elementary/Secondary (0-12) College (1-4or 5+) Night Watcher Agriculture 12 of Health and Mental Hygic I Item 27 is marked other r other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Franz Rosmeisl Martha Funke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum QDCS. 1899 Shady Hill Terrace, Winter Park, FL 3279:
ce of Disposition (Name of Date 20c. Location - City or Town, State Heidi Knauft/sister FL 32793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bohemia Manor Cemetery 5-4-2006 | Chesapeake City, MD 22. Name and Address of Facility R. T. Foard Funeral Home, P.A. 21. Signature of Funeral Service License 318 George Street, Chesapeake City, MD Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition Pticemia Pnysician resulting in death) /Medical Due Id (or as a consequence of): **Examiner** steomy elits Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transil the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day for 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be Answir 2 ☑No 3 ☐ Probably 4 ☐Unknown 1 Tes Be Completed peeu Wanteryto peu, o 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' julietes certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No 1 patient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 ⊟Natural 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Hobertal Manteline M 00053675 5/2/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Monteleone, MD ST-209, Elkton, MD 111 W. High Street, 21921 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAY 0 3 2006 books Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of	Maryla	ınd / Dep		t of H	lealth a	and M	ental Hy		006	15593
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Exa	amine	er	la. Facility Name (If not institution	give street and number	•	antil	-40. City,		usk			40.0	Wicon	
Fund	oral		5. Social Security Number	6. Sex 7.	Age (In yr	s. last birthday,		r 1 Year	If Under	1	8. Date of Bi	rth	9. Bir	thplace (State or Foreign
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death with the Maryland	1	Funerai	11. Marital Status	12. Was Deced	ent Ever in	U.S. 13.	Was Dece			igin? (Spe	cify Yes or No Rican, etc.))- 14	4. Race - Am	erican Indian,
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Ald be Mental	tic •	To B	George Maxwell	Rew					Made	line	Tull			
2 short	ema ema		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mail	ng Address	s (Street a	and Numbe	er or Rura	Route Numb	er, City or	Town, State,	Zip Code)
end :	er tr		Linda Rew Smull	in (Daught					Str					nia 23421
Pages 1	or ot	7	20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation	3 □Removal from St		. Place of Disp cemetery, cre	matory or o	me of other plac	e)	D	ate	20c. Loc	ation - City or	Town, State
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permit. Pages Department of Importent: if it	eny ir	1	21. Signature of Funeral S	Kilassa	1	4-1	2. Name a				ORNTON			
		+	Mary Let 23a. Part1. Enter the disease, or	complications that cau	-	eath. Do not en							ey, V	A 23421 Approximate
Philippin			shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.	1/			_		,			Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)	a. Due to (or	as a cons	equence of):	1900	Up	466					
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ifficate g phys	s the			d										
wrequires that the death certifica been signed by the attending ph	use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23	ld. Date of de	livery
death	d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birt	nt at lime o		□Ectopic p □ Other (s _t						Month	Day Year
by the	itache	hys	9 Unknown	9□ Unknow							-			
The law requires that ate hes been signed b	De de	ρ	Part II. Other significant condition		th but not r	esulting in the t	inderlying o	ause give	en in Part I		1			the cause of death?
requir	pnor	ted	PNEUMON	17-7							10	Yes 2	No 3∏b	robably 4 Unknown
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sicien: T certificat	irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital:	estimat 0	☐ ER/Outpatie	-+	Oth	0.00		Check only	- 10	T0	
iding Physicien: th. : After this certifice	eral d	\vdash	27. Manner of Death	28a. Date of	Injury	28b. Time o		28c. Injun	4 □ Nu		ne 5 Res			icity)
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i or Attending efter death. Director: Afte	by th	Certification:	3 Suicide 6 Could r	ined 288. Place o	f Injury - Al	home, farm, st	reet, factor	y, office		2	8f Location (Street and wn, State)	Number or R	ural Route Number,
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To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certifica	completely filled in by the	Med	29b. Signature and title of certifier	and manne			29	c. License	e number			29d. Date	signed (Mon	h, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene?

			For State			l / Depa	artment of	Health ar	nd Mental Hy	170	006	15594
			Registrar			Ce	rtificate of	Death		Reg. No.		
	Physicia	an	Decedent's Name (First, Middle		livera				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Pedro		TAGE	ι			04	27	2006	182200
	Examin	er	4a. Facility Name (If not institution,			,	4b. City, Town,	or Location of	Death		unty of Death	
				6. Sex 7. Age	(In yrs. la	ofer st highday)	If Under 1 Year	If Under 24	Hrs. 8 Date of Bir	th VV	iconic	O State or Foreign
	Funeral Director		056-32-4125	187M 20 5	66	Yrs.	Months Days		Min. 8. Date of Bir (Month, Da 5/14/1	iy. Year) 939	Count	ace (State or Foreign ry) TO Rico
7			Usual Residence of Decedent		00							
rejau	how	L	10a. State 10b. County			Town or Lo	ocation				10	d. Inside City Limits
N C	all leaves	cto	Maryland Wico	mico	Heb	ron						1X Yes 2 No
G Z I Z I 3-0030 filed within 72 hours efter death with the Mandand	f Heelin and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28s-1 show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	10e. Street and Number 6648 Oak Ridge	Drive			10f. Zip Code 2183	30		10g. Citizen	of What Count SA	ry?
de de	E B	ner	11. Marital Status	12. Was Decedent E	Ever in U.S	. 13.	Was Decedent of	Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.))- 14.	Race - America	
0 4	a a	T	1 ☐ Never Married 2 【 Marri	Armed Forces? 1 ☐ Yes 2 🖔 N tf Yes, Give	10		1 Yes, specify Cut	Specific	Puerto Rican, etc.) Puerto Ric	an	Black, White, e	
	E		3 Widowed 4 Divorced	Year or Dates:						Sp	ecity: Hisp	oanic
5	nati	ete	15. Decedent (Specify only highes	s Education ! grade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most o	of working	16b. Kind	of Business/Ind	ustry
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3 5	Hyg other ant,		17. Father's Name (First, Middle, I	ast)				18. Mother's	s Name (First, Middle	, Maiden Sui	mame)	
ar yidan	Mental Hygiene arked other the atic avent, the	To Be	Pedro Rivera					Fra	ncisca Neg	ron		
, Mar	27 is m		19a. tnformant's Name/Relationsh Susan A. River						or Rural Route Numb ., Hebron,			Code)
ַ ע	f Heelth item 27 other tr		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Name of matory or other pla	acal .	Date	20c. Locati	ion - City or Tov	vn, State
Dallillor	0		1 ☐ Burial 2 ☐ Scremation 4 ☐ Donation 5 ☐ Other (Sc			-	ry Cremat		5/1/06	Sal	lisbury	MD
	Depertment Important: i any injury o		21. Signature of Funeral Service	icensee		2:	2. Name and Addr	ess of Facility	al Home Pr	ofessi	ional Ac	ssociation
O 8	82 2 2		WElla	lleyn C	FSP		501 Snow	Hill	Rd., Salis	bury,	MD 2180)4
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each lin	the death. ne.							Approximate Interval Between
	hysician		tmmediate Cause (Final disease or condition	- ADU	LT	RES,	PIRA TO	RY	DISTRESS	541	DRUME	Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as a	a conseque					/		
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	ng ph as th	Med	IF FEMALE:									
	ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcome		death 3	Ectopic pregnanc	су		23d.	Date of deliver	,
, a	the a	Physician/Med	1 Yes 2 No	4☐Pregnant at 9☐Unknown	time of dea	ath 5	Other (specify)				MOILI	Day Year
T ad	ed by detac		Part II. Other significant conditio	ns contributing to death by	ut not result	ting in the u	nderlying cause o	ven in Part I	23e Did t	obacco use (contribute to the	cause of death?
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VICES: T	ficate or, pe	ပိ	25. Was case referred to medical	7 -					1 Yes	21X No		200 No
> sicia	s cert lirect	ToBe	examiner?	Hospital: 10 tapation	ot 2 🗆 🗆	P/Outpation	nt 3 DOA	Mar	of Death <i>(Check only only of Death (Check only of </i>		1015-110-11	<u></u>
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	er de racto by th	Certification:	3 Suicide 6 Could n 4 Homicide determi		ury - At home. (Specify)	ne, farm, st	reet, factory, office)	28f. Location (City or To	Street and N	umber or Rural	Route Number,
وَ د	rai Di											
DIVISION OF VITAL MECOLDS, F.O. BOX 60 To the Hospital or Attending Physician. The law requires that the death requires	within 24 hours effer death. To the Funeral Director: Affer this certificate has been si completely filled in by the funeral director, pege 2 should	edical	29a. Certifier 1 Certifying (Check only one) Medical 8	g Physician: To the best of Examiner: On the basis of and manner sta	examination	fedge, deat on and/or in	h occurred at the t vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time,	cause(s) and date and pla	d manner as sta ice, and due to	ited. the cause(s)
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,	2 11		30. Name and address of person	who completed cause of di	eath (ttem 2	23a) (Type.	Print)	1101		-7/	0,10	
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	Sta Registr		31. Date filed (Month Day, Year)	2006 32 Registra	ar's Signatu	ire A	arks	· · · · · · · · · · · · · · · · · · ·				

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Amend item#1,per/ID 0855,5/16/06 TT
State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 23a,b,,23PtII,25,27,28a-f per ME, 0856,06/09/06 dhbas No. 2 0 0 2. Date of Death 1. Decedent's Name (First, Middle, Last) LeFaune Younker Rankin Month :36 **Physician** 2006 -LeJaune Younker Rankin 4pri /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County

9. Birthplace (State or Foreign
Country) Washington County Hospital Hagerstown Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2X F 81 22 1924 Maryland Director 220-16-3989 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or iteme 23a or 28a-f ebow Examinar must be notified at 1 ☐ Yes X☐ No Funeral Director Maryland Washington Boonsboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8507 Mapleville Road 21713 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X]No tf Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) d 2 should be filed within 72 hours after the and Mental Hygiene.
27 le marked other then "natural", or flee traumatic event, the Medical Exert 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Self Employed Tupperware Company 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any lighty or other traumatic event some Be John E. Younker Agnes Shoemaker Younker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Marie Taylor (daughter) 2005 Dexter Drive Falls Church Virginia 22043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial PK 5-3-2006 Williamsport Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee un 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Muyout) 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart valure. List only one cause operach line.

Resophageal Obstruction by food bolus with complication and Death

Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of) Box 68760 attending physicien Physician/Medical the SE IF FEMALE: USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day for 4_Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a for t_0 ME Wash Blvision of Vital Records, P.O. 9 Unknown 9 Hinknown cete has been signed by , page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic obstructive pulmonary disease, Hypertensive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? atherosclerotic cardiovascular disease 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2☑ No al or Attending Phyelcian: T s after death.
Il Director: After this certificet of in by the funeral director, p? 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 PInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) X Yes 25 No 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month. Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 04/09/2006 5 Pending 1 Naturat 6:00 р.м Choked on food bolus 1 ☐ Yes 2X No investigation 2 Accident 6 Could not be determined 28f Location (Street and Number or Rural Route Number, Fairley Keedy Home, 8507 Mapley Le Rd., Boonsboro, MD 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Thomicide To the Hospital o within 24 hours aft To the Funeral Di nursing home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D2145 5/400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVZ. HACIERSTURY. MI 12821-OAKHII(MD-1H-10 HBDUL WATHERD, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State parke Registrar

31. Date filed (Month, Day, Year) State MAY 0 1 2006 Registrar

Latshm

V

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



anathan

MD

DO 5

APRIL 30 2006

		1 - State Registrar	State of Maryland / De	partment <i>ertificate</i>	of Health a of Death	and M	ental Hygie _{Reg}		15597
		1. Decedent's Name (First, Middle, Last)	` /				2. Date of Death	Day Year	3. Time of Death
Physici /Medic		/eresa K. 87.	md				Month	28 06	5:24AM
Examin		4a. Facility Name (If not institution, give s	treet and number)		own, or Location			4c. County of Death	
		Riderwood Village			ver Spri			Montgome	
Funeral Director		5. Social Security Number 6. Sex 326−36−1179	7. Age (In yrs. last birthd	Months	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, You January	ear) Coul	place (State or Foreign ntry) Illinois
pu *		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or	r Location					10d. Inside City Limits
sho	5	MD Montgome		Spring					1 X Yes 2 □ No
the M	ect	10e. Street and Number		10f. Zip C	`ada		100	. Citizen of What Cour	ata (2
with	급	3160 Gracefield R	oad #1426		904		109	USA	itty:
eath	eral				nt of Hispanic Ori	igin? (Spe	city Yes or No-	14. Race - Americ	can Indian
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. If marked other then "neturel; or Items 23a or 28e-f show other treumatic event, Ite Marical Examination and the milling and the market market.	by Funeral Director	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	If Yes, specif	y Cuban, Mexicai	n, Puerto F	Rican, etc.)	Black, White,	
2 hou	ed	15. Decedent's Educ	ation 16a. De	cedent's Usual	Occupation		16	b. Kind of Business/In	dustry
Z nic	Completed	(Specify only highest grade	College (1-4or 5+)	ive kind of work ie. DO NOT use	: done during mos retired)	st of workin	g		,
d with	mo:	Elementary/Secondary (0-12)		wner				Plumbing	
othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name	(First, Middle, Ma.		
uld bu Aenta rked rice	ToE	John Karner			Ter	esie	Jelinek		
shour should have		19a. Informant's Name/Relationship (Typ	pe, Print) 19b. M	ailing Address (Street and Number	er or Rural	Route Number, C	ity or Town, State, Zip	Code)
and 2 alth a		Miles Smid/ Son	15	216 Cen	tergate	Drive	Silver	Spring, N	D 20905
item		20a. Method of Disposition	20b. Place of Di cemetery,	sposition (Name	e of ner place)	Da	ate 20	c. Location - City or To	own, State
Page nent on int: If		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	Memoria	1 Garde	ns Cemet	ery5	/15/06	Fort My	ers, FL
permit. Pages 1 and 2. Department of Health at Importent: If item 27 is eny injury or other treu		21. Signature of Funeral Service License	6	22. Name and	Address of Facili	ty Robe	rt F Fr	ans Funera	1 Uomo
8858		MOL		16000	Annapoli	s koa	d Bowie	MD 2071	5
Miles !		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do not	enter the mode	of dying, such as	cardiac or	respiratory arrest		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Attornsclour	for Alo	ant)	15/1	Cr	>	Onset and Death
/Medical	П	resulting in death)	Due to (or as a consequence of):	100 ME	un I	y occ	00		ici.
Examiner		Sequentially list conditions D							5
	ner	Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying	Dualto (or as a consequence of):						
ficate be executed physician and is the burial-transit	Examin	Cause (Disease or injury that initiated events							
e exe		resulting in death) Last	Due to (or as a consequence of):						
ate be hysic he bu	dicai	d							
ntifica ing pl	a a	IF FEMALE:							
death certific	Physician/M	23b. Was decedent pregnant in the past 12 mbnths?	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pre	gnancy			23d. Date of delive Month	Day Year
e dea	Sici	1 ☐ Yes 2 XNo 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 Other (spec	cify)			Month	Day
res that the de igned by the a be detached f	Phy						22a Did tahaa		and the same
res th	by	Part II. Other significant conditions con	mouting to death but not resulting in th	e underlying cat	use given in Part i	١.		co use contribute to the	
v require been sig	ted						T Tes	2 12 No 3 □ Prob	ably 4 Unknown
e law has b	Completed						24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
The ate b	Son						performed 1 ☐ Yes 2		2 No
sien: artific ctor,	Be (25. Was case referred to medical examiner?				of Death	Check only one		
Physicien: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	To	1 ☐ Yes 2 ☐ Ao	ospital: 1 Inpatient 2 ER/Outpa					e 6 Other (Specify	y)
ft e	on:	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	e of 280 ry	c. Injury at Work?	2	8d. Describe how	injury occurred	
eath.	cati	2 Accident investigation		М	1 Yes 2	No			
or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory,	office	2	8f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
the Hospitel or Attending hin 24 hours atter death the Funerel Director: After apletely filled in by the fune									
Hosp 4 hou Fune ely fii	ical	(Check only 2 Medical Examin	icien: To the best of my knowledge, de er: On the basis of examination and/o	eath occurred at r investigation, in	t the time, date an n my opinion, dea	nd place, a th occurre	nd due to the caus d at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	one)	and manner stated.		License number				``
Vith Con	-	29b. Signature and title of Sertifier	/				290.	Date signed (Month,	ыну, теаг)
		Mennile	MA		004337	75	14	128/06	
		30. Name and address of person who con					,	/	
			.60 Gracefield Roa	d Silv	er Sprin	ng, M	D 20904		
Sta	ite	31. Date filed (Month Day, Year) 200	Registrar's Signature						

		1 - For State Registrar	State of	Maryland		artment <i>rtificate</i>			ind M	-	giene Reg. No	2006	5 1	5598
Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, & Garnett M. Shive 4a. Fecility Name (If not institution, & Lawrelwood Care	Ly ive street and num	ber)		4b. City, To		Location o	f Death	2. Date of Dea Month May	1 4c.	Yea 2006 County of De 2011	8	e of Death
Funeral Director				7. Age (In yrs. las		If Under 1		If Under 2 Hours	Min.	8. Date of Birt (Month, Da August	h y, Year)	9. B	Country)	tate or Foreign Ount,VA
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23e or 28e-f show any njury or other traumatic event, the Medicul Evar it is trust be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County MD Ceci 10e. Street and Number 100 Lawrel Drive 11. Marital Status 1 Never Married 2 Married 3 Ni Widowed 4 Divorced 15. Decedent's (Specify only highest Selementary/Secondary (0-12) 17. Father's Name (First, Middle, La Benjamin Morris 19a. Informant's Name/Relationship Tucker Matthews/ 20a. Method of Disposition 1 Namial 2 Cremation 3 4 Donation 5 Other (Spe	12. Was Dece Armed For 1 Yes If Yes Give Year or Da Education grade completed) College (1- st) (Type, Print)	dent Ever in U.S. ces? 20 No tes: 4or 5+)	16a. Dece Give life. I BOO	10f. Zip C 219 Was Deceder f Yes, specification 1 Yes 2 kind of work DO NOT use	121 Int of Hisy Cubar Cocupa done of retired Street a Out	specify: Ition furing most 18. Mothe Sal Ind Numbe Urive 9) 0	of workings of workings of workings of the control	(First, Middle, Perdue, Route Number Late, 12006	USA 16b. Kir RG Maiden :	4. Race - Ar Black, Wi Specify: W id of Busines 2tail Surname)	1 Country? merican India nite, etc. hite ss/Industry , Zip Code)	
Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	therose for as a conseque trial	Do not ent Clerco ance of): Fiburance of):	18 Geo er the mode	of dying	Stre g, such as	et,	· Foard Chesape respiratory ar	eake	City,	Approx Interva	1915
The could us, F.C. BOX 00100, The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No 9 □ Unknown Part II. Other significant condition:	1 Live bir 4 Pregna 9 Unknor		leath 3 ath 5	Ectopic preg	:ify)	on in Part I.		1 🗆 Y 24a. Was: autop	obacco us	24b. Were	to the cause Probably autopsy find	_ ^
ng Physician: dier this certifice	Certification: To Be Col	25. Was case referred to medical examiner? 1	28a. Date o (Month		R/Outpatien 28b. Time of Injury	28c	_	r: 4 Nui	rsing Hon 2		2 No ne) dence 6 now injury	1 Ye	eecify)	
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the tu	Medical C	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person with the certifier of the certifier of the certifier of the certifier of the certifier one) 31. Date filed (Month Ray Year)	Physician: To the leminer: On the ba and mann Color Society Society Society Society Society Society Society Society MD	sis of examination	on and/or inv	vestigation, in	n my op	oinion, deat	h occurre	d at the time,	date and	place, and du	ie to the car	
St Regist	ate	31. Date filed (Month Asy Year)	2006 32.	gistrar's Signatu	* A	park			1					

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No... 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year **Physician** 1:30pm M 2006 May 1. Lillian Marie Skora /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery If Under 1 Year If Under Months Days Hours 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months 1 ☐ M 2 🕱 F Mar 15, 1913 Director 93 525-16-6947 Kansas Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits al Hygiene. I other than "natural", or Items 23a or 28a-f show vent. Ita Nedical Examinar must be rollified at 10a State 10b. County 1 ☐ Yes 2 No Montgomery Village Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20886 9642 Horizon Run Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or Iter any jury or other traumatic event. The Medical Examinations. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professional Artist Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Walter Guffey Ina Ronsick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Bohannon (Daughter) 9642 Horizon Run Road, Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2, 2006 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State May 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia DeVol Funeral Home 21. Signature Funeral Service Licenses 22. Name and Address of Facility 10 East Deer Park Drive Gaithersburg, MD 20877 MILLA 23a. Part1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oue week æ Due to (or as a consequence of): /Medical Examiner eha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the upderlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? þ 2 1 No 3 Probably 4 Unknown 1 | Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 4 No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Plac 1 Death Check only one Hospital: 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after ounerel Direct 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 DO4165 VKalystDusch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (LINOSERTBIRSCHBAXCH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 03 2006 Registrar

			For State Registrar	State of Mar		artment of F rtificate of		d Mental Hyg	giene Reg. No.	106	156	500
	Physici		1. Decedent's Name (First, Middle, Last) Barbara Jean Scully					2. Date of Dea Month May 1.	Day 2006	Year	3. Time of 7:00	f Death
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	r Location of D			nty of Death		
			14000 Eagle Court			Rockt					gomery	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days		Ain. (Month, Day	h (, Year)	Count		
	Director		213-58-5118 Usual Residence of Decedent		57 Yrs.			November	19, 194	8 Wasnir	igton,	ш.
	yland how		10a. State 10b. County	1	0c. City, Town or Lo	cation				10	d. Inside C	
	e Ma	cto	Maryland Montgomery		Rockv	ille					1 🗌 Yes	2 🔀 No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		ry?	
	eath v	eral	14000 Eagle Court	2. Was Decedent Eve	erin II S 13 1	20853		(Specify Yes or No-		USA ace - America	n Indian	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-f show among injury or other treumetic event, the Medical Exam and the modified of an once.	by Funeral	1 ★ Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	? (Specify Yes or No- uerto Rican, etc.)		lack, White, e	tc.	
Maryland 21215-0036	in 72 hou n "nature	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NDT use retired	during most of	working	16b. Kind of	Business/Ind	ustry	
212	d with giene.	com	Elementary/Secondary (0-12)	College (1-4or 5+)	P	articipant			S	helter W	orksho	p
g	De file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sum	ame)		
<u>ya</u>	should bund Ment	To	John L. Scully, Jr.					et C. Duniga				
Mar	d 2 sh th and t7 is m treum		19a. Informant's Name/Relationship (Typ Margaret C. Scully/ Mot			-		<i>Rural Route Numbe</i> Blvd, Silver	-			
<u>ب</u>	t Health item 27		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	20)	Date	20c. Location	n - City or Tov	vn, State	
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		Metropolita	-	Ma		Alexand	ria. Vir	rinia	
Baltimore,	permit. Departm Importe any inju		21. Signature of Juneral Service Licenses					neral Home 1		2007	- Jan-	
<u> </u>	90E 99		mohen	Lole				W, Silver Sp		d 20901		
7	Pnysician /Medical		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Probable A	spiration P		ig, such as card	diac or respiratory an	rest,		Approximat Interval Bet Onset and I	ween
	Examiner			Down Syndn								
	₽ =	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a c	consequence of):							
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a c	concequence of):							
8760,	be ex ician burial			Due 10 (01 as a 0	onsequence on.							
687	ficate physis the	edical	d.								to desirable de la Constantina	
Box (eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of		35			23d. E	Date of deliver	y	
	death	sicla	in the past 12 months? 1 ☐ Yes 2 🔀 No	1 Live birth 2 (4 Pregnant at tin 9 Unknown]Ectopic pregnancy] Other (specify)				Month [Day ^	Year
<u>Р</u>	that the de ed by the a detached	Phy	9 Unknown					00- 014				
Ś	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions cont Seizure Disorder, B12 D		•	, , ,	en in Part I.		bacco use co es 2 🔼 No			
Vital Record	The law ate has b page 2 s	Completed						24a. Was a autop: perfor	sy med?	prior to com death? 1 Yes 2	pletion of c	available ause of
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	anital.		100		Death (Check only or	16)			
	Phys this al dil	To	1 Yes 2 No	spital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatien		4	g Home 5 X Resid				
on	Attending Phy r death. ector: After thi by the funeral o	tlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Injury	Wor	k? Yes 2 ☐ No	200. 2630106 11	ow injury occi	31160		
Division of	l or Attending after death. Director: After I in by the funer	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow		nber or Rural	Route Num	ber,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of r er: On the basis of ex and manner stated	kamination and/or in	occurred at the tirvestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time, d	ause(s) and r late and place	manner as sta e, and due to t	ted. he cause(s	;)
	To the I within 2. To the I complet	Me	29b. Signature and title of certifier	^-	, ,	29c. Licens	e number	2	29d. Date sign	ned (Month, D	ay, Year)	
	il) Lits A	ela 1	m)	DI	049:	3	5-	2-01	6	
	4		30. Name and address of person who con John Saia,				2, Rockv	ille, MD 208	154			
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 3 20	32. gistrar's	s Signature	out						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene)

		•	1- State of Maryland / Department of Health and Certificate of Death		ene2006 [560]
	Physici		1. Decedent's Name (First, Middle, Last) JOHN SAMUEL STILLIONS	2. Date of Death Month NAY 9	Day Year
	/Medio Examin		4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL FREDERICK	ath	4c. County of Death FREDERICK
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		Year), 1927 9. Birthplace (State or Foreign Country), Maryland
	Aaryland I ahow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Frederick Frederick		10d. Inside City Limits 1XXves 2 □ No
	with the Maryland 3a or 28a-f show at be rectified at	i Director	10e. Street and Number 10f. Zip Code 21701	10	og. Citizen of What Country?
920	hours after death with the Maryland tural', or Itama 23a or 28a-f ahow al Examiner must be rectified at	by Funerai	3 Widowed 4 Divorced Year or Dates:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	I within 72 liene. r than "nai	Completed	15. Decedent's Education (Specify only highest grade completed) Bementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) Equipment Operator		6b. Kind of Business/Industry Crane Service
and 2	d d d	Be	17. Father's Name (First, Middle, Last) Tolum Tracemon Chilling Tracemon Manual Manua	ame (First, Middle, M	faiden Sumame)
Maryland	12 should h and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship (Type, Print) Mrs. Nancy E. Stillions, wife 223 East Fourth Street	Rural Route Number,	City or Town, State, Zip Code)
Baltimore, I	. Pages 1 and Iment of Healt tant: If Item 2 jury or other		20a. Method of Disposition XXSurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Lutheran Cemetery Management	Date 2	Jefferson, MD
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee MO0255 22. Name and Address of Facility Keeney and Basfo 106 East Church S	ord PA Fundation Freder	eral Home rick, MD 21701
68760,	Physician /Medical Examiner bhysicien and streep physicien and streep p	edicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	viQ Visase of	L lungs > 10 yrs.
.O. Box 68	death certif e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4□ Pregnant at time of death 3□ Ectopic pregnancy 1□ Live birth 2□ Fetal death 3□ Ectopic pregnancy 5□ Other (specify) 5□ O		23d. Date of delivery Month Day Year
<u>α</u>	luires that the de n signed by the a	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death? s 2 No 3 Probably 4 Unknown
Records,	sician: The law requires that the centificate has been signed by the lirector, page 2 should be detache	Completed by	Coronary artery disease	24a. Was an autopsy perform	prior to completion of cause of
on of Vital	ng Phy Ifter this Ineral c	To Be	25. Was case referred to medical examiner? 1 Yes	eath (Check only one Home 5 Resider 28d. Describe how	nce 6 Other (Specify)
Division	al or Attendi after death I Director: A d in by the ft	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai C			
		Me	29b. Signature And the Analysis Madeen Miles Solo 3/6	29	d. Date signed (Month, Qay, Year)
	3		30. Name and address of polson who completed cause of death (from 23a) (Type Print)	Hawsto	un MS 21742
	Sta Regist		31. Date filed (Month, Day, Year) 32 Registra's Signature	17	,

06-03140 Peggy A. Smith

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

eggy A. Smith		For State Registrar	or waryland /	•	icate of De		u Wienie	ai i iygic		g No.	200	6 1560
Physicia	ın/	Decedent's Name (First, Middle,Last)				_	l M	ate of Death	Dav	Year	3. Time of Death 1724 hrs
Medical Exami		Peggy 4a. Facility Name (if not institution, give	Ann street and number)		Smith 4b.C	ty, Town, or	Location of		ay 9, 200		ounty of Death	
		Memorial Hospital				ımberland		- W. To			gany	10.
Funeral Director		5. Social Security Number 6. Se 2 2 0 - 5 2 - 9 5 0 8 1	1	(In yrs. last t		Jnder 1 Year onths Days	_	Min	Date of Birth 3 / 02 / 1		Foreig	thplace (State or on untry) Maryland
my		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location							10d. Inside City Limits
and show a	5	MD Alle	gany			Cumbe	rland					1 X Yes 2 No
ath with the Maryland items 23a or 28a-f show any set be notified at once.	Director	10e. Street and Number			10f	Zip Code	E 0.3		10	-	of What Cour JSA	ntry?
with the	a la	506 Park Str 11. Marital Status	eet 12. Was Decedent B	Ever in U.S.	13. Was De	cedent of His					. Race - Ameri	can Indian, Black,
death or item	Funeral	1 Never Married 2 Married		X No		ecify Cubar		uerto Rica	n, etc.)		White, etc.	7.
rs after ural", miner	2	3 X Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates: ly highest grade com	pleted) 16	a. Decedent's Us		tion (Give kir		done		e <i>cify:</i> Wide of Business/I	hite
5 72 hou in "nat	etec	Elementary/Secondary (0-12)	College (1-4 or 5		during most of		. DO NOT us	se retired)		M		
-003 I within giene. ther the	Completed	17. Father's Name (First, Middle, Last)			Lab	orer	18.Mother's	Name (Firs	st, Middle, M		anufact	uring
215. be filed ntal Hy rked of	Be	Leroy	Wilson		ingler			uerit			ıriel	Miller
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's Name/Relationship (T Patty L. Fleegle			19b. Mailing Add							, Zip Code) Ld, MD21502
e, M 1 and 2 Health item 2	ł	20a Method of Disposition		20b. Plac	ce of Disposition	(Name of ce		Da	_		cation - City or	
imor Pages nent of ant: 11 or othe		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify:		101	crest M	em. Pa					nberlan	·
Balt permit. Departi Import		21. Signature of Funeral Service Licen	see			and Addres: Decatu						Home, P.A. 21502
Physician	1	23a. Part I. Enter the disease, or comp failure. List only one cause on ea		the death. Do							,	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a.	Multiple in Due to (or as a conse									Death
A		Sequentially list conditions, b.	Due to (or as a conse	equence or).								
	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c.	Due to (or as a conse	quence of):								
red nsit	Examiner	events resulting in death) Last	Due to (or as a conse	quence of):								
50, te be executed ysician and burial - transit	Medical	X UNPENDED	AMENDED ite	em#23a,2	27,28a-f,p	erÆ,g8	56,6/15	6/06 TT	1			
760, ficate be g physici s the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnar		aath 3	Ectopic	oregnancy			Date of deliver	y Day Year
x 68 tth certi	Physician/	past 12 months? 1 Yes 2 No 9 Unknowr	4 Pregnant at	time of death	- =	(Specify)		oregria.ie,				
Division of Vital Records, P.O. Box 687 tall or Attending Physician: The law requires that the death certific and price death. **All Director** After this certificate has been signed by the attending I led in by the funeral director, page 2 should be detached for use as the content of the	Phys	Part II. Other significant conditions	9 Olikilowii	but not resu	Ilting in the under	lying cause	given in Part	t I.	23e Did to	bacco use	e contribute to	the cause of death?
, P.C rres that signed be deta	d by								1 Yes	2 🗸 N	lo 3 Prol	bably 4 Unknown
ords tw requi	Completed								24a. Was a autops perfor	sy		utopsy findings available completion of cause of
Rec The la ficate h	Com	Constitution of the Land			<u> </u>	Of Plan	e of Death (0	Shook only	1 Yes 2		1 🗸 Y	es 2 No
of Vital Records ing Physician: The law requ After this certificate has been tuneral director, page 2 should	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 EF	R/Outpatient 3	DOA DOA	Othor	Nursing Ho		Residenc	e 6 Othe	r.
n of Ving Phy After th	-	27. Manner of Death	28a, Date of Inju (Month, Day,Y	ry 28 ear)	8b. Time of Injury		ury at Work?	1	Describe h	ow injury	occurred	
Sior Attend r death ector: by the	icatic	2 Accident Investigat	29a Diago of In		e, farm, street, fa		Yes 2X I	28f.	Location (S	treet and	Number or Ru	ural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification	3 Suicide 6 X Could not determine	be	ailroad				Ba	or Town, S Itimore	St.	Cumberla	nd, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Medical C		ian: To the best of m									
To Too	Me	29b. Signature and title of certifier	and manner stated			29c. Licens						onth, Day, Year)
		Clathe	ul	looth /lis :: ce	20)	0.0.	.M.E.			May 1	10, 2006	
		30. Name and address of person who Laron Locke MD. Assis	completed cause of data transfer in the completed cause of data transfer in the complete cause of data transfer in the complete data transfer in the complet		^{3a)} 111 Penn St	reet, Balti	more, ME	21201				
	tate	11111/4 19/0000	32. Registra	r's Signature	South &							
Regis	ucli	MAY 1 7 2008	1 10 poll - 60 B	E. 5" A	E COMPANY							

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 5 200c

HRRISON

Registrar's Signature

			For State Registrar			Marylan	•	artmen rtificat					g. No.	006	15604
	Physici	an	1. Decedent's Name (First RUTH R. S'		1							2. Date of Deat Month	23 ^y	2Ŏ06	3. Time of Death 1:00PM M
	/Medic Examir		4a. Facility Name (If not in		street and numb	er)		4b. City,	Town, or	Location	of Death			nty of Death	1
			TALBOT HO							TON			1	TALBO	
	Funeral Director		5. Social Security Numbe 219–36–599	1 1	M 2 X F	Age (In yrs. 94	(ast birthday) Yrs.	If Under Months	Days	if Under Hours	Min,	8. Date of Birth JUN 22,	^Y 13911	9. Birthp	lace (State or Foreign
	rland ow		Usual Residence of Dece 10a. State 10b.	County		10c. Cit	y, Town or Lo	ocation		-				1	0d. Inside City Limits
-	a-fsh iified	ctor	MD	TALB	OT		EAS	TON							X □Yes 2□No
	72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show offer Examiter must be notilited at	Funeral Director	10e. Street and Number	TON CITE				10f. Zip		1601		10	0g. Citizen o	of What Coun	•
	ns 23¢	eral	403 S. HANS		12. Was Decede	ent Ever in U.	.S. 13.	Was Deced			igin? (Sp	ecify Yes or No-	14. P	lace - Americ	
9	after o		1 Never Married	Į.	Armed Force 1 ☐ Yes 2 If Yes, Give	s?		If Yes, spec 1 ☐ Yes		n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	8	lack, White,	
21215-0036	hours ural',	d by	3 Widowed 4 E		Year or Date	s:							Spe	WI.	CTE
2	within 72 ene. than nat	Completed	(Specify on	Decedent's Edu ly highest grad	e completed)	F.)	(Give	dent's Usua kind of wo DO NOT us	rk done a	<i>luri</i> ng mos	t of work	ing	16b. Kind of	Business/Inc	dustry
	filed with Hygiene other the ant, It e	Com	Elementary/Secondary	(0-12)	College (1-4	or 5+)	REGIS	TER O	F WI	LLS		1	STATE	OF MAJ	RYLAND
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natur any injury or other traumatic event, It e Madical once.	Be	17. Father's Name (First, EDWARD KE)		Dibib							e (First, Middle, A FEWART	faiden Sum	ame)	
٦	should nd Mer marke matic	은	19a. Informant's Name/F				19b. Maili	ng Address	(Street a			a/ Route Number,	City or Tow	m, State, Zip	Code)
	and 2 alth ar alth ar 27 is		ANASTASIA	S. COOP	ER/SIST	ER		-				, EASTON	-		
Baltimore,	Pages 1 and of He int: If itam		20a. Method of Disposition		lemoval from St		Place of Dispo emetery, crea	osition (Nar matory or o	ne of ther place	9)	1	Date 2	20c. Locatio	n - City or To	wn, State
III III	it. Pag rtment rtant: njury c		* 4 ☐ Donation 5 ☐ 0	Other (Specify)			RING H	-				7/2006	EAST	ON, MAI	RYLAND
Ba	permit. Departr Imports any infi		JOHN		nERCE!	200	FE	2. Name an LLOWS	, HE	LFENI	BEIN	& NEWNAL	M FUNE	RAL HO	OME PA
	Pnysician /Medical		23a. Part1. Enter the dis shock, or heart failt Immediate Cause (Final disease or condition resulting in death)	ease, or compl	ications that cau ne cause on eac a	sed the deat	n. Do not ent	ter the mod	e of dying	g, such as				,01	Approximate Interval Between Onset and Death 3 - 44 kmw
68760,	Examiner. bhysician and sthe burial-transit	edical Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, ate	>	as a conseq									
.O. Box	es that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Haill		2 ☐ Feta t at time of d	I death 3[⊒Ectopic pr] Other (sp						Date of delive Month	ry Day Year
rds, P	The law requires that the ste has been signed by the bage 2 should be detache		Part II. Other significant	c onditions cor	ntributing to deal	h but not res	ulting in the u	ndertying c	ause give	on in Part I.					e cause of death? ably 4 Unknown
Il Records,	The law recate has been page 2 sho	Completed									_	24a. Was an autopsy perform	ed?	o. Were autor prior to con death? 1 Yes	osy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to examiner?		fospital:				Othe			n (Check only one			
	ding After fune	ion: To		Pending investigation	1 L Inp 28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		8c. Injury Work	at		me 5 Resider 28d. Describe hor	nce 6 X IO w injury occ	ther <i>(Specify</i> urred	HOSPICE
Division of	To the Hospital or Attanowithin 24 hours after death To tha Funaral Diractor:	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place of building	Injury - At ho etc. (Specify	ome, farm, str v)				-	28f. Location (Str. City or Town,		mber or Rurai	Route Number,
	To the Hospital or A within 24 hours after To the Funaral Dirac completely filled in by	edical C	29a. Certifier 1 (Check only one)	Certifying Phys Medical Exami	sician: To the be ner: On the basi and manne	s of examina	wledge, death tion and/or in	n occurred vestigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ca ed at the time, da	use(s) and r	nanner as sta e, and due to	ated. the cause(s)
	To ti Withi To ti comp	W	29b. Signature and title of	f certifier	1/		Mon	290	License	number 146	6	29	d. Date sign	ned (Month, I	Day, Year)
	-10-	1	30. Name and address of	1				ALC: N	מת ת	17.4	emort	MD 2164	11	1	
í	Sta	te	LUDWIG J. 31. Date filed (Month, Da	-		M.D., istrar's Signa		TUMOO	אע עי	. EAS	PTUN	, MD 2160) I		
	Registi	_	APR	2 5 200	5	a d		Ale					100		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🌖 🕦 💍 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year SMILLIF **Physician** HENRIETTA 10:30 AM Apri 2006 27 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min 94 Yrs. 145-38-7611 26, 1911 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow other treumatic event, the Madical Examiner noust be notified at Annapolis Maryland Anne Arundel 1 Tyes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 1601 Old Mill Bottom Run 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: ģ 3₩idowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then 'eny injury or other treumatic event, the Men College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Schlegel Emil Ludwig Loos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Gibson/daughter 1579 St. Margaret's Road Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 4/29/2006 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signatur Ineral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive Physician 24 hrs resulting in death) /Medical Due to (br as a consequence of): Examiner Kena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physician and d be detached for use as the buriel-transit the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Disease Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No ို 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number dun 8on 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. HUTCHINSON

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 0_1 2006

32. Registrar's Signature

1	Street	-	0	1
	C	0	U	D

			1 - State Registrar			Ce	rtificate (of L	Death			Reg. No.			
3			Decedent's Name (First, Middle, La							2. Date of De			3. Time o	of Death	
	Physici	an	Severino R. Sa	antoo Im							Month	Day	Year	_	
	/Medio			antos Jr			c> T		1 2 1		April	27, 2		6:00	P M
	Examir	ier	4a. Facility Name (If not institution, give				4b. City, Tov			Death			nty of Death		
· ja			Gladys Spellman l				Chev		9				ce Ge		
	Funeral Director		,	Gex 7.7 1 X M 2 □ F	Age (In yrs. Iz 78	ast birthday) Yrs.	If Under 1 Y Months Da	'ear 'ays		Min.	8. Date of Birt (Month, Da May 4.		Cou	place (State ntry) Lippin	_
	ס		Usual Residence of Decedent								1100 19				
	show		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	City Limits
	be filed within 72 hours after death with the Maryland tial Hygiene. bd other than "natural", or Itema 23a or 28a-f show event, the Medical Evants or mat be notified at	Funeral Director	MD Prince (Geroges	Воч	wie									2 □ No
	or 2	<u>=</u>	10e. Street and Number				10f. Zip Co	de				10g. Citizen	of What Cou	ntry?	
	23a	62	12904 Crickmore	Trace			207	20				USA			
	de.	ne	11. Marital Status	12. Was Deceder Armed Force			Was Decedent	of His	spanic Origin	n? (Spec	ify Yes or No-	- 14. F	lace - Americal		
9	afte or It	五	1 ☐ Never Married 2X Married	1 Tes 20			1X Yes 2□								
8	ral.	l by	3 Widowed 4 Divorced	Year or Dates	s:		120 105 2	INO	Specity.	АБІА	.11	Spe	cify: Asi	Lan	
21215-0036	72 h natu licel	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Dece	dent's Usual Or	ccupa	tion	of workin	_	16b. Kind of	Business/In	dustry	
7	- ·	ğ	Elementary/Secondary (0-12)	College (1-4o	or 5+)	life.	kind of work do DO NOT use re	etired)	uning most o	JI WOIKIII	9				
21	filed withi Hygiene. other then	no.		5+		Agric	ultura.	1 S	pecia	list		Wor	ld Bar	ık	
	offled of Hygie other fent, II	0	17. Father's Name (First, Middle, Last)					18. Mother's	s Name	(First, Middle,	Maiden Sum	ame)		
a	id be enta ked	To B	Severino Santos	Sr.					Mart	ha V	iri				
2	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, Ina Mi	-	19a. Informant's Name/Relationship (19h Marlin	ng Address (Sti	reet at				r Cituar Tau	Ctoto 7in	Codol	
Maryland	s 1 and 2 should f Health and Mer item 27 le merke other traumatic		Alicia C. Santos	, ,										(0000)	
	of Health item 27 other tr		20a. Method of Disposition	s) wile	20h Die		Crick			ce			0720		
0	Pages nent of h int: If ite iry or of		1 X Burial 2 ☐ Cremation 3 ☐	Removal from Stat	te Zou. Fis	metery, crei	sition (Name o natory or other	n place) [Da	110	20c. Locatio	n - City or To	own, State	
Ē	arit. Pagartmen ortant: injury		4 ☐ Donation 5 ☐ Other (Specif		Lake	emont	Memoria	al	Garde	ns 5	/5/06	David	sonvil	le, M	D
Baltimore,	permit. Pages. Department of the important: If its any injury or of once.		21. Signature of Funeral Service Licer	nsee		22	. Name and Ad	ddress	of Facility	Robe	rt E.	Evans	Funera	1 Home	2
m	Den Tang		1 LIN			1	.6000 Aı	nna	polis	Roa	d Bow	ie, MD	2071		
1	44.3		23a. Part1. Enter the disease, or com	plications that caus	ed the death.	Do not ent	er the mode of	dying	, such as ca	ardiac or	respiratory ar	rest,		Approximat	te
			shock, or heart failure. List only Immediate Cause (Final	one cause on each	iline.									Interval Bet Onset and	tween Death
100	Pnysician /Medical		disease or condition resulting in death)				ubarach	hno	id Blo	eedi	ng	-2-1		Weeks	5
	Examiner			Due to (or a	as a conseque	ence of):									
	35	_	Sequentially list conditions,		tension								- 42	10 yea	ils
	₽ #	ne	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a conseque	ence of):									
	certificate be executed ding physicien and ise as the burial-transit	Examiner	that initiated events	c											
o,	exe en a rial-l		resulting in death) Last	Due to (or a	as a conseque	ence of):									
68760,	te be ysici	/Medical		_ d.											
68	ifica g ph as th	ed													
×	~ ~ ~		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								234 [ate of delive		
Bo	law requires that the death of as been signed by the attent 2 should be detached for us	Physician	in the past 12 months?	1☐Live birth 4☐Pregnant			Ectopic pregna Other (specify						Month		Year
o.	at the de by the a tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		201	Other (specify	"							
P.O.	that the detail		Part II. Other significant conditions of	contributing to death	but not recult	ting in the u	adorhina onuce		in Don't		330 Did to	bacco use co			1
Vital Records,	res t	þ	Coronary Arte			ung in the bi	idenying cause	y givei	inrant.						
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ပ္ပ	law ras be	pie									24a. Was a		. Were auto	psy findings	available
ď	The late hapage	Completed								_	autops	med?	death?	noletion of c	ause of
ta	iffica or, p	CO	25. Was case referred to medical				-		OC Plans of	4 Danta I	-	2X No	1 🗌 Yes	2L No	
5	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	tient 2□E	D(O: += ++ = =		Other			Check only or			711117	
of		\vdash	27. Manner of Death	28a. Date of In		28b. Time of	1 JU DON		4 (M 14012)		d. Describe h			<i>'</i>)	
n	Attending Phy r death.	9	1 Natural 5 □ Pending	(Month, D	Day Year)	Injury		Work?		_	d. Describe III	ow injury occi	TILEO		
Si	tand death tor: the	cal	2 Accident investigation 3 Suicide 6 Could not be	A					es 2 No						
Division of	or Al	Certification:	4 Homicide determined	289. Place of I	njury - At hom etc. <i>(Specify)</i>	ne, farm, str	eet, factory, offi	ice		28	 Location (Si City or Town 	treet and Nun n, State)	nber or Rura	l Route Num	ber,
	ital or ral Direction	ပ္													
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1X Certifying Ph	ysician: To the bes	of avamination	ledge, death	occurred at the	e time	, date and p	olace, an	d due to the c	ause(s) and r	nanner as st	ated.	
	he h in 24 he F plete	edi	one)	and manner s	stated.	on and/or my	estigation, in it	пу орп	nion, death (occurred	at the time, d	ate and place	, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	shl	,	īn	29c 1ic	ense i	number 5	0 /	V 1 2	9d. Date sign	ed (Month, L	Day, Year)	
			* Keller	Land A	1		DI	6	175	, (10	4/2	#10	6	
•			30. Name and address of person who	completed cause of	death (Item 1	23a) /Tuno	Print)					1			
								1	MD C	2070	-				
		700	Revathy Murthy 31. Date filed (Month, Day, Year)	6130 Land	trar's Signatu		Chever1	LУ,	MD Z	20785)				
	Star Registra		MAY 0 1	F1.	Occor 4	M A	coals 1								
	11-11-11	- 1	MILLI O T	C000	1	100									

			1 - For State Registrar		Maryland / Dep Ce	artment of I		Re	19. No 2 U	06	158	507	
П	Physicia	an	Decedent's Name (First, Middle, La					2. Date of Death	Day	Year	3. Time of 6:30	Death A M	
	/Medic	al .	JOHN RUDOLPH 4a. Facility Name (If not institution, given	SATLER	er)	4b. City. Town. o	or Location of Dear		25 2006 4c. County of Deat		0.30	A W	
	Examin	er	4a. Facility Name (If not institution, give street and number) CORSICA HILLS NURSING HOME CENTREVILLE						QUEEN ANNE				
Funeral			5. Social Security Number 6. S	Sex 7.7	Age (In yrs. last birthda)				9 Birthplace (State or Foreign				
	Director		158-09-9740	I X M 2□ F	87 Yrs.			SEPT.8,	1918		JÉRSEY	[
Maryland 21215-0036	d within 72 hours after death with the Maryland giene. It han "natural", or items 23e or 28e-f show the Madical Examinar must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				T.	0d. Inside Ci	ity Limits	
			MD QUEEN ANNE QUEEN ANNE						1 ☐ Yes 2 X No				
		l Direc	10e. Street and Number 1711 RUTHSBURG	10f. Zip Code 2165	7	og. Citizen of V	g. Citizen of What Country? USA						
		Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	1	□No s:1940–1946	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☒ No edent's Usual Occur	Specify:			ck, White,	HITE		
			(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Give kind of work done during most of work if the DO NOT use retired) ATTORNEY						LAW				
	Hyg othe ent,	0	17. Father's Name (First, Middle, Last			2.2.014.0.2	18. Mother's Na	me (First, Middle, N	faiden Suman	ne)			
	0 0 0	ToB	RUDOLPH JOHN SA	AILER			A	LICE DRAK	CE DRAKE				
lar	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	s 1 and 2 of Health item 27 I		KATHARINE G. SAII 20a. Method of Disposition	ER/ WIFE	20b. Place of Disg		G ROAD,	OUEEN ANN	E, MD :				
altimore,	t. Page rtment o rtant: If		1 XBurial 2 Cremation 3		cemetery, cri	smatory or other pla	DAT						
ıĦ			'4 □ Donation 5 □ Other (Special Service Lige			22. Name and Addre	ess of Facility		HESTER'				
ä	permi Depar Impo any ir once.		Lavmes K.	Sellen	hern F	ELLOWS, H	ELFENBEI FRTY ST	N & NEWNA	M FUNEI	RAL H	OME, F 617	'.A.	
P.O. Box 68760,	Physician /Medical	Ilcal Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. The three the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. The three the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.										
	te be executed system and surial-transit serial-transit serial-tra		Causs. Enter Unuanymy Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.										
	The law requires that the ate has been signed by th page 2 should be detache	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnanc	у		23d. Dai Mo	te of delive	,	Year	
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
Il Records,		Completed	Possible lune malignances						4a. Was an autopsy autopsy performed death? Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
Vital	Physician: Th this certificate al director, paç	Be	25. Was case referred to medical examiner?	Hospital:	1	_ lon	ner \	ath (Check only one					
o): To	1 Yes 2 No 27. Manner of Death	28a. Date of Ir		of 28c. Injur	ry at	fome 5 Resider			1)	-	
Division	l or Attending Fafter death. Director: After in by the funer.	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No										
		ertification;	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Str. City or Town,		er or Rura	l Route Num	ber,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	To the within 2 To the comple		29b. Signature and title of certifier	M	/	29c. Licens	se number	29	d. Date signed	-			
)	MICO	rden, Mis	V	75937		4.2	-5.0	76		
			30. Name and address of person who 6/0 1/ul chman	completed cause o	of death (Item 23a) (Type	Print)	21601						
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 7	1 27	strar's Signature	Grade ,	/						

			For State Registrar	State	of Marylan	_	artment of H		nd Mental H	ygiene Reg. No.	2006	5 1560	E
			Decedent's Name (First, Middle		2. Date of D	eath		3. Time of Death	-				
	Physici		Monika Ann Slamen				April	28	200				
4	/Medio		4a. Facility Name (If not institution	4b. City, Town, or Location of Death			4c. County of Death			-			
£.	LAGITIII	-	Shady Grove Adv	ventist H	Mospital		Rockv	ille			Montgomery		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		irth		rthplace (State or Foreign	_
	Director		215-60-9000	1 ☐ M 2 🛣 F	53	Yrs.	Months Days	Hours	Min. (Month, E	ay, Year) 195		Canada	
			Usual Residence of Decedent						ICD.	, 155	3	Callada	-
	/lanc		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits	
	Man	ţō	Maryland Monto	gomery		Rock	ville					1 ☐ Yes 2 No	
	288 101	Director	10e. Street and Number	10f. Zip Code			10g. Citiz	10g. Citizen of What Country?					
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or itema 23e or 28e-f ahow sht, the Medical Examinar must be rediffed at	0	14832 Bauer Dr	20	853			US	27				
	eath	Funeral	11. Marital Status		cedent Ever in U	S. 13.1			2 (Specify Yes or N	lo- 1	4. Race - Ame		_
	ter d	'n.	1X Never Married 2 Marri	Armed F			f Yes, specify Cuba	n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)		Black, Whi		
99	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	live		1□Yes 2□xNo	Specify:		1 3	SpecifyWhi	.te	
ğ	tura	ed	15. Decedent's Education 16a. Decedent's Usual Occupation					ation		16h Kin	16b. Kind of Business/Industry		
5	in 72 in ma	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo						f working	100.14	0 01 00311033	unidustry	
2	with ene.	E	Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper								Techno	10011	
8	Hyginther the		17. Father's Name (First, Middle, I				DOORKE	-	Name (First, Middl			Togy	
ä	od be	Be	Jan Slamen						Maurer	.,	,		
Maryland 21215-0036	d Me mark matic	ဥ	19a. Informant's Name/Relationsh	nin (Tuno Brint)		10h Mailie	and Address (Street		or Rural Route Num		T C1-1-	7-0-41	_
<u>s</u>	d2 s h an 7 is u		Anna Slamen/ Mo						Rockville				
	1 and tealth 2		20a. Method of Disposition		20h F		sition (Name of						_
altimore,	1 or 1	8	1 ☑ Burial 2 ☐ Cremation	3 Removal from	1 6	semetery, crer	natory or other place	ө) Ма	ay 3,	20c. Loc	ation - City or	Town, State	
	men tant:		4 ☐ Donation 5 ☐ Other (Sp		Gat		aven Cemete	- ,	2006	And the second		ng, Marylan	d
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any lairy or other traumatic event, I'm Mardical Examinar must be retilled an once.		21. Signature of Funeral Service I		le	F1 50	Name and Address rancis J. 00 Univer:	s of Facility Colli sity B	ns Funera 1vd, W, S	l Hom ilver	e Inc. Sprin	a, MD 20901	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between the production of the complete										
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f.	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):							_
	LAGITITICI		Sequentially list conditions,		GUMON							Unbown	
-	₽ #	Inel	cause. Enter Underlying	Due to	(or as a conseq	uence of):							
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				Untrans						
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8760	cate be executed physician and the burial-transit	dlcal		d. CE	للسال	TIS						Un bown	
9	eath certific attending p	d)	IF FEMALE:										
Вох	death certifi e attending I ed for use as	ian/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 Feta	death 3	Ectopic pregnancy			23	d. Date of del Month	. ,	
0	0 0	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unkr	nant at time of d	eath 5	Other (specify)				MONTH	Day Year	
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ś	igner bed	þ	Part II. Other significant condition	ns contributing to d	death but not res	ulting in the ui	nderlying cause give	n in Part I.				the cause of death?	
Records,	w require been sign	Completed							_ 1	Yes 2□	No 3 □ Pr	robably 4 Unknown	
ပ္ပိ	e law r has be	pie							24a. Wa	s an	24b. Were au	utopsy findings available completion of cause of	
	The l	E O							peri 1 ☐ Yes	ormed?	death?		
<u>ta</u>	ilcian: Th certificate rector, pag	a	25. Was case referred to medical					26. Place of	Death (Check only		12,103		_
>	ystcian: is certific director,	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Nnpatient 2 🗆	ER/Outpatien	t 3 DOA Othe		ng Home 5 ☐ Res		Other (Sae	vc(fv)	
0	ding Ph	Ë	27. Manner of Death	28a. Date		28b. Time of			28d. Describe			ony,	-
Ö	ath. r: Aff	atio	1 Natural 5 ☐ Pending investig	9	iiii, Day 19ai)	Injury		r ∕es 2 ∐No					
Division of Vital	or Attending Physician: after death. Director: After this certifica in by the funeral director.	ill ill ill	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flac	e of Injury - At ho	ome, farm, str	eet, factory, office		28f. Location	(Street and	Number or Ru	ural Route Number,	-
ā	5 # 5 S	Certification:	* - Nothicide	Duild	ling, etc. (Specif	y)			City or 10	wn, State)			
	To the Hospital or Ai within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	xaminer: On the b	e best of my kno basis of examina nner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and p inion, death o	place, and due to the occurred at the time	cause(s) a , date and p	nd manner as lace, and due	s stated. to the cause(s)	-
	With Common	×	29b. Signature and title of certifier	\cap	O 1	12	29c. License				signed (Monti		
			· Vedel	Hann	UZ 1	イリ	D00 6	2995)	April	29	2006	
i			30. Name and address of person v	who completed cau	ise of death (Item	23а) (Туре,	Print)	~	^	14.)		_
1-			Petek Donne		400	dical	Center	Dr	ive loc	kville	*, HD	20850	_
	Sta Registr		31. Date filed (Moral) Day, Yor)	2006 32	Registrar's Signa	S A	relie						

	•	For State Registrar	State of Ma	arylar				ealth a D <i>eath</i>	nd M	-	giene Reg. No. 2	006	1560
Physician	0.7	1. Decedent's Name (First, Middle, Last	5000	-11	-					2. Date of De Month		Year 9	3. Time of Death
/Medica Examine	r	4a. Facility Name (If not institution, give University of Ma 5. Social Security Number 6. Se	my land Me.	licul a (In vrs.	(ester	Ba	115	Location of		8. Date of Bir	B	2006 ounty of Death	750
Funeral Director			²		Yrs.	Months	Days	Hours	Min.	(Month, Da 1/14/	y, Year)	Cour WV	ntry)
a-f ehow	ctor	10a. State 10b. County DE Sussex			ty. Town or Lo Iilton							1	0d. Inside City Limit 1 XYes 2 □ N
Name of the Market of the Proceedings of the Procedure of		10e. Street and Number 25568 Front St	reet			10f. Zip	Code 199	68			-	n of What Cour	ntry?
a within 72 hours after death with the Maryland liene. rithen "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at Completed by Europea Director.	2	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 7 1 If Yes, Give Year or Dates:			Was Dece f Yes, spe 1 ☐ Yes	dent of Hi cify Cuba		in? (Spe Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White, pecify: Whi	etc.
c * 30 =	Completed	15. Decedent's Edit (Specify only highest grad	College (1-4or 5	i+)		kind of wo DO NOT u	rk doné a se retired,	luring most	of worki	ng		of Business/In	·
be filed at othe event,	e n	12 17. Father's Name (First, Middle, Last) Howard Nichol	son		Sch	001	Tea	18. Mother		(First, Middle,		h Scho mame)	001
s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev		19a. Informant's Name/Relationship <i>(T</i>) John S. Spera (H			2556	8 Fr	ont	nd Number	or Rura	Route Numbe	e 199		
Page nent o int: if iry or		20a. Method of Disposition ↑ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		4	Place of Dispo cemetery, cren Olive	matory or o Met	ther place h . Ce	∍m. 5	5/5/	/2006		tion - City or To ⊇m , WV	wn, State
permit. Depurin Importa any nju		21. Signature of Funeral Service Licens Dand J. Mask	11/ 1	0103				s of Facility in St	наг	bert Salem,	Fune:	ral Ch 5426	ape1
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each lir	10.							rest,		Approximate Interval Between Onset and Death 7 minths
death certificate be executed as eattending physician and control of for use as the burial-transit control of the control of t	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	,	<u>ا</u> عادد د	\ E	ffusi	`0\\	\$			1 week
death certiff de attending of for use as	Iysiciati/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3	Ectopic pr Other (sp					23d	. Date of delive Month	ry Day Year
igne d	2	Part II. Dther significant conditions co	ntributing to death b	ut not res	ulting in the ur	iderlying o	ause give	n in Part I.		23e. Did to			e cause of death?
The farate has page 2	naidino							-		24a. Was autop perfor 1 \(\text{Yes} \)	sy	prior to con death?	osy findings available pletion of cause of
Physician: The College	0	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	lospital:	nt 2 🗆	ER/Outpatien	1 3□ DC	Othe			Check only on		Other (Specify	')
D 0 0 0		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	y Ye <i>ar)</i>	28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y		2	8d. Describe h			,
		3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.							City or Tow	n, State)		Route Number,
thin 24 hours the Fune most the Fune multipletely fill Medical	פחוכש	29a. Certifier Certifying Phy (Circuit Circuit) 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	өхапппа	wledge, death tion and/or inv	occurred estigation	at the time in my op	e, date and inion, death	place, a occurre	nd due to the o	ause(s) and late and pla	d manner as sta ice, and due to	ated. the cause(s)
To t	2	29b. Signature and title of certifier)				License		136		9d. Date si	gned (Month, L	Day, Year)
1.00		30. Name and address of person who co		eath (Item	1 23a) (Type, I			135D			11104	, , , , , ,	_006
1-12 State	41	Jeffrey Dina 31. Date filed (Month, Day, Year)	32. Registra	ス人 ir's Signa	S. Gr	rene	. St	eet,	Bal	timore	Mary	and 21	201

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 15610 1- For State Certificate of Death Reg No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day April 3, 2006 17:20 CHARLES RAYMOND SWARTZ 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Washington Hagerstown 11 West Baltimore Street If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country) Months Days Hours Min 33 219-72-8534 JAN. 2. 1973 $1 \times M$ MARYLAND Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 10b County 1 X Yes 2 No HAGERSTOWN MARYLAND WASHINGTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 W. BALTIMORE ST., APT. 801 21740 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces?

1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married White, etc. Married 4 X Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: WHITE ð 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry during Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) 12 STUDENT COMMUNITY COLLEGE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RAYMOND CHARLES SWARTZ DELORIS ELIZABETH REESE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND C. SWARTZ/FATHER 23 MADISON AVE., APT. 1, HAGERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c, Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Department or Important: SMITHSBURG CREMATORY 4/08/2006 SMITHSBURG, MARYLAND Donation 5 Other Specify 9 Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Part I. Enter the disease, Boonsboro, Maryland 21713 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each lipe.

Hypertensive cardiovascular disease Retween Onset and /Medical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and - transit The law requires that the death certificate be executed Physician/Medical XUNPENDED X AMENDED item#1,23a,PII,27,perME,g856,6/23/06 TT ending physician use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year 2 Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown certificate has been signed by the sctor, page 2 should be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably 4 Fatty liver, sleep apnea Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 ✓ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitly filled in by the funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 27 Manner of Death 1 X Natural 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. To the 1 within 2 To the 1 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E 410-106 30. Name and address of person who completed cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Blown It Registrar ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

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Sene Franklin Tea	Jr. State of M	aryland / Department of	of Health and Mental	l Hygiene		
	- For State	Certificate of	of Death	Po	2 No. 2 (106 1561
Dhysisian	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Deat	g No	3. Time of Death
Physician Medical Examine				Month	Day Year	1600 hrs
Medical Examine	Gene Franklin Te			May 9, 200		
	4a. Facility Name (if not institution, give street	and number)	4b. City, Town, or Location of D	reath	4c. County of E	Jeath
	402 Alabama Avenue		Salisbury		Wicomico	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 2			Birthplace (State or
Director	219 17 9062 1X M 2	F 24 Y		Min. 12/04	/1981	oreign Country) MD
	<u> </u>			112/04	1901	Country) MD
à	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Loca	ation			10d Inside City Limits
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Sa-f sho	MD Queen Ann	e's Chester	town			Tes 2 X No
tor 28a-f show	10e. Street and Number		10f. Zip Code	10	g. Citizen of What	Country?
he line	2430 McGinnis Ro	ad	21620		USA	
s 23.	11. Marital Status 12. V	las Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - A	merican Indian, Black,
or items 23	1 X Never Married 2 Married		Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	White, e	tc.
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5-0036 ed within 72 hour lygiene. other than "natu		during	most of working life. DO NOT use		16b Kind of Busin	ess/industry
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thirthir in the state of the st	12	5+ Wai	ter		Rest	aurant
5-0036 iled within 72 l Hygiene. I other than "t th Medical E	17. Father's Name (First, Middle, Last)		18.Mother's N	lame (First, Middle, M	laiden Surname)	
21 21 be fill rked rked	Gene Franklin Te	at Sr.	Jenn	ifer Joa	n Jones	
Mer Mer	19a Informant's Name/Relationship (Type, Pr	int) 19b Ma ifi	ng Address (Street and Number			State, Zip Code)
MD 21215-0036 3 2 should be filed within 7 127 is marked other than unarked other than 170 for the 170	Gene Teat Sr./Fa	ther 2430	McGinnis Rd	Cheste	rtown M	D 21620
	20a. Method of Disposition		osition (Name of cemetery,	Date	20c. Location - Ci	
Baltimore, permit. Pages I ar Department of Hea Important: If iter injury or other tr	1 X Burial 2 Cremation 3 Re	moval from State crematory or c	other place)			
Baltimore permit. Pages I Department of F Important: Ifi	4 Donation 5 Other Specify:	Crumpto	n Cem.	5/14/06	Crump	ton MD
mit. port	21. Signature of Funeral Service Licensee	22.	Name and Address of Facility	3 - 11 - 17		
E E E M	Zo. Part I. Enter the disease, or complication	Į F	ellows, Helf	enbein &	Newnam	F. Home
Physician	23a. Part I. Enter the disease, or complication	s that caused the death. Do not enter	the mode of dying, such as card	iac or respiratory arre	est, shock, or heart	MD 21651 Approximate In erval
/Medical	failure. List only one cause on each line					Between Onset and Death
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med !	Due to	(or as a consequence of):				
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	if any, leading to immediate Due to cause. Enter Underlying Cause	(or as a consequence of):				
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the death certificate be by the attending physicic ched for use as the burish	IF FEMALE: 23c 23b. Was decedent pregnant in the	If yes, outcome of pregnancy			23d Date of de	
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tal Recipient: The certificate	25. Was case referred to medical		26.Place of Death (Ch	neck only one)	<u> </u>	
Vital Rechysician: The this certificate all director, page	examiner? 1 ✓ Yes 2 No	1 Inpatient 2 ER/Outpatie	nt 3 DOA Other N	lursing Home 5	Residence 6 🗸	Other: Scene
Ing Physi		Ba. Date of Injury (Month, Day,Year) 28b. Time o	f Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. The law rection: After this certificate has been signed by the funeral director, page 2 should be detach.	1 X Natural 5 Pending	(Month, Day,Year)	1 Yes 2 No			
Sior Attend death ctor:	2 Accident Investigation					
or A	Suicide Could not be	8e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (S or Town, S		or Rural Route Number, City
Division o spital or Attending tours after death. neral Director: After	4 Homicide determined	Specify)				
Hosa 24 hc Fun tely	29a. Certifier 1 Certifying Physician: To	the best of my knowledge, death occ	urred at the time, date and place	, and due to the caus	e(s) and manner as	started
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic properely filled in by the funeral director, page 2 should be detached for use as the built of the control of the control of the control of the property of the proper	one) 2 Medical Examiner: On the	e basis of examination and/or investig	ation, in my opinion, death occur	red at the time, date	and place, and due	to the cause(s)
To the Ho within 24 To the Fu completely	29b. Signature and title of certifier	nanner stated	29c. License number		29d. Date signed	(Month, Day, Year)
		7/ 1	O.C.M.E.		May 10, 2006	
	/ beader Me	14 Lower	J.J. J.			
	30. Name and address of person who comple)			
	Theodore King MD. Assistar	t Medical Examiner 111 F	enn Street, Baltimore, M	D 21201		
Sta	31. Date filed (Month, Day, Year)	32. Registra s Signature	1 4			
Registr	MAY 12 ZL	32. Registra & Signature	A Carlo			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Physician Tucker Wilhelmenia April 26 2006 12:55 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bradford Oaks Nursing & Rehab. Center Clinton Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug. | 4 Ug. | 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕏 F 350-22-4399 75 Director Chicago, Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ahow Ft. Washington 1X Yes 2 □ No Directo Prince Georges 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 20744 3703 Ashboro Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ∐Yes 2. ANo fYes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2☐XNo Š Specify: Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates: naturai Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Education Reading Aide permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygier Importent: If them 27 Is marked other ti eny injuryor other treumatic event, ILL once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Ana Brown Ernest Hunt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3703 Ashboro Ct. Ft. Washington, Md. Aaron Tucker -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Jefferson Memorial Pk. May 6,2006 Jefferson Boro, Pa. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Latney's Funeral Home, Inc. 3831 Georgia Ave. N.W. Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pancreatic Cancer Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate hes been signed by the a page 2 should be detached I ☐ Yes 2 🖾 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2X No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completaly filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of cortifler 29c. License number 29d. Date signed (Month, Day, Year) D19431 April 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Frank M. Ryan, M.D. 31. Date filed (Month, Day, Year)

03

2006

could

32. Rigistrar's Signature

11701 Livingston Rd. #103 Ft. Washington, Md.

20744

			Department of Health and M Certificate of Death	ental Hygier	2000	15613
		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
Physici /Medic		Jonah Nathaniel Urg	vhart	April 2	5 2006	12:10 P. M.
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	,
		30331 Bowland Court	Princess Aun		Somers	et
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthple Countr	ce (State or Foreign
Director		776 46 0131 1 le	Yrs.		7,1936 5055	ef, Virginia
and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10	d. Inside City Limits
Aarylan Febow	ō	Maryland Somerset Pri	ncess Anne			1√□Yes 2□No
the M	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Countr	y?
3a or	0	30331 Bowland Court	21853		U.S.A.	
rs after death with the Maryla rs of terms 23a or 28e-1 ehov	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - America	
or Ite		1 Never Married 2 Married 1 Yes 2 Anno	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, et	c.
ours a	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give / Year or Dates:	To res 280 No Specify.		Specify: Bla	cK
72 hours "naturel",	Completed	, 15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work)	ng 16b.	Kind of Business/Indu	istry
ithin Paris	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	F	arming I	ndustry
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ntal h	Be	C 1 = 1 = 1 +	Englis	(D)		
2 should be filed within 72 hours after death with the Maryland and Mental Hygens. Is marked other than "naturel; or Items 23s or 28s-1 show aumetic event, the Mudical Examinational be mailled at	To		. Mailing Address (Street and Number or Rura			Code)
2 0 0 0		Robert Ungshart Son 1	11	000	idelphia P	A. 19119
tem 27		20a Method of Disposition 20b. Place of		-	Location - City or Tow	
Pages nent of h		1 MBurial 2 U Cremation 3 Li Hemoval from State	mount Cemeter 51	3/06	Phila dela	P.A
permil. Pages 1 and J Department of Health Important: If item 27 eny injury or other tr onge.		21. Signature of Fungral Service Licensee		thony E.	Ward F. t	1,
age a		Aut En Warl h.	30639 Hampden			rel 21853
		23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac o		/	Approximate nterval Between
Physician			CARDIAL INFARC	TION		Onset and Death
/Medical		resulting in death) Due to (or as a consequence				
Examiner		Sequentially list conditions, b	ASCVD			
D 15	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ji).			
and -trans	Kam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	nt)·			
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death certificate to attending physic of for use as the b	Physician/Medical	d			ĺ	
certif ding	//We	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliven	,
atter d for u	clar	in the past 12 months? 1 ☐ Yes 2 ☐ No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month C	ay Year
the achee	hysi	9 Unknown				
wrequires that the deben signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
quire an sig				1 ☐ Yes	2 ☐ No 3 ☐ Probal	oly 4 Unknown
aw re	plet			24a. Was an autopsy		sy findings available oletion of cause of
Or VICAL INC. Physicien: The law r this certificate has b	Completed			performed	death?	□ No
ien: artifica ctor. I	Be	25. Was case referred to medical exagainer?	26. Place of Death			
hysic his ce I dire	101	1 Ves 2 No Hospital: 1 □ Inpatient 2 □ EP/Ou		ne 5 Residence	6 ☐ Other (Specify)	
ding Pl			njury Work?	28d. Describe how in	jury occurred	
eath.	cati	2 Accident investigation	M 1 Yes 2 No			
or Att	ertification:	4 Homicide determined 28e. Place of Injury - At home, fa	rm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural i ate)	Route Number,
Livision of vices in the control of the law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and cimpletely filled in by the funeral director, page 2 should be detected for use as the burial-transit	O	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge	death assured at the time, date and place.	and due to the severe	(c) and manner as star	
Hos 24 ho Fun stely f	edical	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge of the best of				
thin the mple	Mec	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Da	ay, Year)
ठ न इ न) N V +9	D 48098		4/25/06	
		30. Name and address of person who completed cause of death (Item 23a)				
		Karon than Vi	(Type, Print) 201 Hu	il web	1 md Z	(8/7
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist	rar	APR 2 8 2006	Anough)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

end #19b Per INF 8860 10/27/06 JH
State of Maryland / Department of Health and Mental Hygiene
State Amend #10a-f Per FH G860 10/12/06 JH
Registrar
Registrar Amend #19b Per Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 28,2006 **Physician** 8:00 Рм Ann R. Urbani /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Wicomico 27534 Crooked Oak Lane 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Director 026-42-1478 November 5,1951 Massachusetts 54 Usuet Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits Florida Palm Beach 28a-f show other traumatic event, the Medical Examiner must be notified at XX Yes 257No Director Delray Beach Maryland Wicomico Salisbury 524 S. Mallory Circle 10f. Zip Code 10g. Citizen of What Country? ö filed within 72 hours after death with 33483 or Items 23a 2180127534 Crooked Oak Lane USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specity. 3 ☐ Widowed 4 ☐ Divorced Specify: "natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Phyllis Hurley Louis Radinovic 19a. Informant's Name/Relationship (Type, Print) 19b. 5249 AgdresMarket 394-44/mooter Rutab Roberturbary CiBeratoch State. 2183483 27534 Crooked Oak Lane Salisbury, Maryland 21801 David Urbani/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 5/2/06 Salisbury, Maryland 21. Signature of Fungran Service Lifensee pnce HOLLOWAY Funeral Home P.A. /del 1501 Snow Hill Rd. Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Endo metria Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 2 No 1 TYes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an has autopsy certificate 1□ Yes 2 or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 🗌 Yes Other: 4 Nursing Home Certification; To ome 5 esidence 6 Other (Specify)
28d. escribe how injury occurred 27. Magner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After Natural 2 Accident 5 Pendina To the Frosposs.

Vithin 24 hours after death.

To the Funeral Director: Alt investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only one) the 286. Signature and title of 29c. License number 30. Name and address of person who completed cause of dean (Ite 23a) (Type, Print) Sostel Heprie 31. Date filed (Month, Day, Year) MAY 0 2 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) (1) State
Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Dav 8:00 P.M. /Medical GLORIA WOHLLEB APRIL 22,2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Hospital Elkton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 12/24/1929 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □ F Months 089-22-2977 76 Director Maspeth, NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at Director 1 Yes 2 No MD Cecil Elkton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 85 Woods Way 21921 or Items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Jeweler Jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Bowman ျှ Henrietta Gebhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: if item 27 is any injury or other tra-Kathleen S. Valetutti/Daughter 45 White Pine Circle, Elkton, Md 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Calvary Cemetery 1 \$\begin{align*}
 Burial 2 □ Cremation 3 □ Removal from State 4/29/06 Woodside, Nv 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcial Service 22. Name and Address of Facility Strano & Feeley Family Funeral Home 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Obstructive Pulmonary Disause Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 menths? Month 4☐Pregnant at time of death 5 Other (specify) Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 23e. Did tobacco use contribute to the cause of death? Completed 3 Probably 4 Junknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending nours after death.

neral Director: A
filled in by the for investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of confifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

118 North St Suite 3 B Election 00023322 MD 21921

State Registrar

P.O. Box 68760

Division of Vital Records,

			For State Registrar	State of M	larylar		artmer <i>rtificat</i>			and Me		giene Reg. No.	006	15617
			Decedent's Name (First, Middle, I	.ast)							2. Date of De	ath	V	3. Time of Death
	Physici /Medi		Virginia	W. W:	ilson						Month	19	O4	1120 M
1	Examir		4a. Facility Name (If not institution, g	ive street and number	.)		4b. City.	Town, or	Location o	f Death		4c. Cou	nty of Death	
			Peninsula legion	nel medica	1 Ce1	rec		Sali	Sbul	4		W	comie	0
	Funeral				ge <i>(In yr</i> s. 35	last birthday)	if Under	r 1 Year Days	If Under a	Min.	8. Date of Bird Month, Da II/I3/	th Ya Yaar)	9. Birth	place (State or Foreign
	Director		219-05-8502	ILM ZKIF (J)	Yrs.					11/13/	1920	Mar	yland
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1.	10d. fnside City Limits
	Aaryl • ho	ō		ico		bron								1⊠Yes 2 No
	28a-	ect	Maryland Wicom. 10e. Street and Number	100	116	DEON	10f. Zig	Code				10g. Citizen	of What Cou	ntn/?
	with Sa or	0	108 W. Church S	treet				21830)			USA	J. 77.121 000	,
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f ehow event, the Medical Exacting must be rediffed at	Completed by Funeral Director	11. Marital Status	12. Was Deceden		.S. 13.1				jin? (Spec	cify Yes or No lican, etc.)	- 14. F	lace - Ameri	can Indian,
(0	r Her	필	1 Never Married 2 Married	Armed Forces						, Puerto P	lican, etc.)	E	Black, White,	
93	ours a	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 ☐ Yes	2 4 No	Specify:			Spe	city: wh	nite
2-0	72 hc	sted	15. Decedent's (Specify only highest of			16a. Dece	dent's Usu kind of wo	al Occupa	tion	of workin	a	16b. Kind of	Business/In	dustry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired)	anny most	or worker	9	_ //		
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Baltimore,	0 0		1 Burial 2 □ Cremation 3		, 9	emetery, crer	natory or c	other place				20c. Locatio	-	own, State
tim	t. Partmentant		4 □Donation 5 □Other (Spe		не	bron C				5/3/0			on, MD	
Bal	permit. Pag Department Important: I any Injury o		21. S. ratu of Funeral S. V. se lo	ensee		22	H8118	way*1 now I	Tuher Till	al Ho Rd.,	ome Pro Salish	ofessio oury, M	onal A ID 218	ssociation 04
			27a. Part1. Enter the disease, or co	mplications that ausely one cause on each	the deat	h. Do not ent	er the mod	te of dying	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or a	s a conseq	uence of):								
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	ס =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):								
	and and trans	Examiner	that initiated events resulting in death) Last	c										
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87(physic physic the b	edical		d										
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Box	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	Ideath 3	Ectopic p						Date of delive Month	Day Year
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ď	that the poly detail		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying c	ause giver	n in Part I.		23e. Did to	bacco use co	ontribute to the	ne cause of death?
Division of Vital Records,	uires sign	d by	Ci	te							1 🗖 Y	′es 2□No	3 Prob	abfy 4 Unknown
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on	ding h. After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	ay Year)	Infury	м	28c. Injury Work?	es 2∐N				5,700	
isi	or Attending after death. Director: After in by the funer	fica	3 Suicide 6 Could not	be One Place of Ir	ijury - At ho	ome, farm, str	eet, factor				Bf. Location (S	Street and Nu	mber or Rura	I Route Number,
Ö	after after Dire	Certification:	4 Homicide		tc. (Specif			, , , , , , , , , , , , , , , , , , , ,			City or Tow	m, State)		
	Hospital 24 hours a Funeral I etely filled	<u>a</u>	29a. Certifier 1 Cartifying I	Physician: To the bes	t of my kno	wledge, death	accurred	at the time	, date and	place, ar	nd due to the d	cause(s) and	manner as si	tated.
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical	one) 2 Medical Ex	aminer: On the basis and manner s	ot examina tated.	tion and/or inv	estigation	, in my opi	nion, deati	h occurred	d at the time, o	date and place	e, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				290	c. License	number			29d. Date sign	ned (Month, .	Day, Year)
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in	null		30. Name and address of person wh	o completed cause of	death (Item	1 23а) (Туре,	Print)				1			
V.	1 opp		Kobet	A. Col	No	218 ture	Neu	Ha !	57	Sali	5 N	D 31)	
0	Sta		31. Date filed (Month, Day, Year) MAY 0 2	2006 32. Regist	rar's Signa	ture	· N							
美	Registr	ar	MAI V &	7000	var ,	KI S	MAN CAN							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0558 JOHN KIRKWOOD WHITE 27,2006 <u>April</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Faston
If Under 1 Year | If Under 24 Hrs. | 8 | 1 Talbot Memorial Hospital 8. Date of Birth
(Month Day, 1937)
DEC 9, 1937 7. Age (In yr 9. Birthplace (State or Foreign 5. Social Security Number Months **Funeral** Days Hours WASHINGTON DC 68 220-32-7124 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other then "natural", or items 23a or 28a-1 ehow traumatic event, the Medical Examinal results for notified at X Yes 2 No CAMBRIDGE DORCHESTER Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 303 BELVEDERE AVE. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if item 27 is marked other then "natural", or ite 1ry or other treumatic event, the Medical Examinal. 1 Never Married 2 Married 1 Yes 2 XNo WHITE timore, Maryland 21215-0036 Specify: Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) 5+ ZONING & PLANNING ATTORNEY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MILTON CHRISTIAN WHITE, JR. JEAN KIRKWOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 110 RIVERSIDE DRIVE, CAMBRIDGE, MD 21613 KAREN B. WHITE/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. **GLENWOOD CEMETERY** 5/1/2006 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON, D.C. 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERO J200 S. HARRISON ST EASTON, MD 21601 JCHP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Dination Physician Meuminia disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown been signed be should be detailed 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 MInpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 TYes 2 □No within 24 hours after deaun.
To the Funeral Director: / investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number ature title of certifie 29b. Sic and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST., EASTON, MD 21601 FAITH JABERS-MATZONI M.D. 31. Date fifed (Month, Day, Year) State MAY 0 1 2006 Registrar

		1	For State Registrar	State of Maryland		artment of H			R	eg. No. 🤈 🎧	06	156	. 9
	Physici	_	1. Decedent's Name (First, Middle, Las						Date of Deal Month	Day	Year	3. Time of C	Death ✓ M
No.	/Medic	al .	JOHN GRAHAM WATS 4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of I	Death (pril	23 2 4c. County	of Death	2110	
1	Examin	er		spital		Easte		Doutt		Tale	. /		
	Funeral Director		5. Social Security Number 6. S		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Min.	Date of Birth (Month, Day)	1		place (State or ntry)	Foreign
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	r 28a-	Director	MD QUEEN A 10e. Street and Number	MME 5 QU	LLMDIC	10f. Zip Code			1	0g. Citizen of	What Cour	ntry?	
	th with		210 WYE FERRY RO)AD		21658				USA			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23a or 28s-f ehow amy Injury or other traumatic avent, the Medical Examinar must be notified at ODGs.	by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WWII		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origii an, Mexican, I Specify:	n? (Specify Puerto Ric	y Yes or No- an, etc.)		ck, White,	can Indian, etc.	
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100	/Medical Examiner		resulting in death)	Due to (or as a consequence of under the	uence of):	S						Years	
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8760,	icate be executed physician and s the burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):								
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Division	To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Diractor: After this completely filled in by the funeral di	Certification;	2 Accident investigate 3 Suicide 6 Could not l 4 Homicide determined	De 290 Place of Injury - At h		treet, factory, office		28	f. Location (S City or Tow	Street and Num. m, State)	ber or Rur	al Route Numb	⊅e <i>r</i> ,
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			30. Name and address of person who										
1	216-K		LAKSHMI VAIDYAN	ATHAN, M.D., 21	9 S. V	NASHINGTO	N STRE	ET, E	ASTON,	MD 2	1601		
	St Regist	ate	31. Date filed (Month, Day Year)	2 6 2006 Meser	UK	Aposte	,						

DHMH 17 Rev 1/2001

Watson, John

06-02997

Gerald Washington

Please Type or Print in Black Indelible Ink

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State of Maryland /	Department of Health and Mental Hygier

	State of Maryland / Department of Health and Mental Hy For State Registrar Certificate of Death	rgiene
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Gerald Thomas Washington	2. Date of Death Month Day Year May 3, 2006 3. Time of Death 1226 hrs
	4a. Facility Name (if not institution, give street and number) Doctor's Community Hospital 4b. City, Town, or Location of Death Lanham	4c. County of Death Prince George's
Funeral / Director	5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 1. Age (In yrs. last birthday	8. Date of Birth(MM/DD/YYYY) 9. 8 inthplace (State or Foreign Country) DC
laryland 188a-f show any 181 once.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Prince George's Landover	10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country?
n the Maryland 3a or 28a-f sh otified at one	10e. Street and Number 7506 Brondle Court 10f. Zip Code 20785	USA
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Titem 27 is marked other than "natural", or items 23a or 28a-f shoor traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban,	Rican, etc.) White, etc. Specify: Black ork done 16b. Kind of Business/Industry
21215-0036 uld be filed within 7 Mental Hygiene mered other than re event, the Medical o Be Complé	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, Maiden Surname) ne Delores HaywoodWashington
ore, MD 21215-0036 ss I and 2 should be filed within 72 hours af of Health and Mental Hygiene If item 27 is marked other than "natural her traumaric event, the Medical Examin To Be Completed by		ural Route Number, City or Town, State, Zip Code) andover, MD 20785
Baltimore, ME permit Pages I and 2 s Department of Health at Important: If item 27 injury or other traums	4 Donation 5 Other Specify: Washington National Cemetery	Date 20c. Location - City or Town, State Suitland, MD
Balt permit Departs Importingury	21. Argnature of Funeral Service Licensees 22. Name and Address of Facility Latney's Funeral H	3831 Georgia Ave., N.W. ome Washington, DC 10011
Physician /Medical xaminer	23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Atherosclerotic cardiovascular disease with the mode of dying, such as cardiac or failure. List only one cause on each line. Atherosclerotic cardiovascular disease with the mode of dying, such as cardiac or failure. List only one cause on each line. Atherosclerotic cardiovascular disease with the mode of dying, such as cardiac or failure. List only one cause on each line. Atherosclerotic cardiovascular disease with the mode of dying, such as cardiac or failure. List only one cause on each line. Atherosclerotic cardiovascular disease with the mode of dying, such as cardiac or failure. List only one cause on each line. Atherosclerotic cardiovascular disease or condition resulting in death)	respiratory arrest, shock, or heart the complications Approximate Interval 8etween Onset and Death
0, be executed sistian and burial - transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.	
50, te be executed sysician and curial - transit	AMENDED item#23a,27,perME, C858,8/44/06 TT	
Ox 6876 ath certificate attending phy or use as the sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery Month Day Year
ires that the de signed by the dedectached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Vital Records, hysician: The law require this certificate has been significated and the forector, page 2 should be To Be Completed		24a Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal R cian: T certific ector, p	25. Was case referred to medical examiner? 1 Ves 2 No Other No No No No No No No No No No No No No	
n of Vi ding Physi a. After this funeral dir	1 Ves 2 No Position 1 Ves 2 No Position 2 ER/Outpatient 3 DOA Normal 4 Nursin 27. Manner of Death 1 XX Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	g Home 5 Residence 6 Other: 28d. Describe how injury occurred
Division of Vital Records. To the Hospital or Attending Physician: The law required the hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should edical Certification: To Be Complete.	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f Location (Street and Number or Rural Route Number City or Town, State)
To the Hosp within 24 hos To the Fune completely fi	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause(s) and manner as started the time, date and place, and due to the cause(s)
F 3 F 3 B	29b Signature and title of certifie O.C.M.E.	29d Date signed (Month, Day, Year) May 4, 2006
	30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201
State Registrar	31. Date filed (Month, Pay, Year) 32. Registrar's Signature	

			1 - For State of Mar	•	artment of F		l Mental Hygi	ene 006	15621
	Physici	an	1. Decedent's Name (First, Middle, Last) Richard Alan Webb, Sr.				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of De		4c. County of De	0
1	Exam.		14823 Clear Spring Rd.			liamspo			nington
-ap	Funeral Director		220-54 - 3966 XXM 2□F	(In yrs. last birthday) 56 Yrs.	Months Days	If Under 24 H Hours Mi		9. B 949 N	irthplace (State or Foreign Country) Maryland
	and and		Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary I-f aho	tor	Maryland Washington	Wil	liamsport				1 □ Yes XXNo
	th the	Directo	10e. Street and Number		10f. Zip Code		10	g. Citizen of What (
	ath w	ral	14823 Clear Spring Rd.			795	/O - // . V	US	
980	should be filed within 72 hours after death with the Maryland nd Mantal Hygiene. I marked other than "natural", or itema 23e or 28e-f ahow I marked other than "natural", or itema 23e or 28e-f ahow I martic avent, I a Medical Exactinar must be rollified at	by Funeral	11. Maritat Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Every Armed Forces? 1 □ Yes ☒ X No if Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 Yes No	Specify:	(Specify Yes or No- erto Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White
2	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	during most of w	vorking 1	6b. Kind of Busines	
21215-0036	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+))	DO NOT use retired	d) -		Techono	mtotion
7	Hygie Hygie Ither t	Co	12 17. Father's Name (First, Middle, Last)	Me	echanic	18. Mother's N	ame (First, Middle, M		ortation
au	0 = 5	To Be	Merrick Austin Webb, Sr.			Ethel	Maye Re	id	
Maryland	permit. Pages 1 and 2 should by Department of Health and Menta important: if item 27 is marked any injury or other traumatic a <u>once</u> .	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Number,	City or Town, State	, Zip Code)
	and 2 ealth m 27 i		Linda Webb - Wife			pring R			yland 21795
Baltimore,	ges 1 if of H or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1	matory or other plac			0c. Location - City of	
<u>=</u>	iit. Pa tritmen triant: njury		4 Donation 5 Other (Specify) 21. Significant of Fineral S				4,2006 H	agerstown	,Maryland
Ba	Depairming Depairming Impo						ome, P.A. gue St.Wil	Liamsport	.MD 21795
v.	Pnysician		23a. Part1. Enter the disease, of complications that caused the shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition	ne death. Do not ent		ig, such as card	iac or respiratory arres		Approximate Interval Between Onset and Death 3 UL OTA
	/Medical Examiner		resulting in death) Due to (or as a	tionsequence of):					0
	×	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events .	consequence of):					
8760,	icate be executed physicien and s the burial-transit	Ical	resulting in death) Last Due to (or as a d	consequence of):					
O. Box 6	death certif e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
Records, P.	as the gned se de	δ	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	V	to the cause of death? Probably 4 □Unknown
õ	s been si should b	oiete	9				24a. Was an	24b. Were	autopsy findings available
		Completed					autopsy perform 1 Yes 2		
Vital	sician: The certificate ha	Be	25. Was case referred to medicat examiner? Hospital:		oth Oth	05	eath (Check only one)	
Division of 1	ding Phys h. After this funeral di	ation: To	1 Yes 2 No 1 Inpatient 27. Manger of Death 28a. Date of Injury Natural 5 Pending (Month, Day) 2 Accident investigation	28b. Time of	f 28c. Injur	4 INUISING	Home 5 Residen 28d. Describe how	nce 6 □Other (Sp v injury occurred	ecify)
Divis		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number.
	To the Hospital or within 24 hours after to the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of eand manner state	xamination and/or in					
	To the within To the comple	ž	29b. Signature and title of certifier		29c. Licens	e number	29	d. Date signed (Mor	nth, Day, Year)
•			Mid Hamde	IM, ML	DI	4641	2	5/2/	04271
N	1-10		30. Name and address of person who completed cause of dea	ith (Item 23a) (Type,	Print)	OPAI	CT.	Hadon	January 140
90	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar	's Signature	1170	UITE		1 19900	newn, Mil
	Registr		MAY 0 3 2006	1. As	antid				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. (2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7:15 P M **Physician** May 16, 2006 Margaret Louise Ames /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Linthicum Anne Arundel Chesapeake Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

O/. Yes Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 24, 1 8 irthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 94 Yrs. 1911 067-09-6289 Argentina Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State nd 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.

27 ie marked other then "neturel", or Itema 23a or 28a-f ehow traumatic event, the Madical Examina must be notified at 1 Yes 2 No Director <u>Annapolis</u> Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 130 Hearne Court, Apt-312 USA Funera Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8 fack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of 8usiness/Industry Colfege (1-4or 5+) Efementary/Secondary (0-12) Travel Industry 12 <u>Travel Agent</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant: if item 27 is marked other Be Edward Ames Millicent Johnson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alice Harrison, Niece P.O. Box 552 Ed ewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. + 05/17/05 Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor 22 Name and Address of Facility
Cremation Society Of Maryland Inc. 299 Frederick Koad Baltimore, Maryland 21228 Approximate Interval 8etween Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final Physician ongestiva disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Meart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The faw requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1□ Yes 2☑No 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No 2 this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: fnjury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of to the Funeral Direct 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death contined at the time date and place, and due to the states (a) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 41419 17, 2006 30. Name and autress of person who completed cause of death (ftem 23a) (Type, Print) ANNAPOLIS, MU) STE. 100 m 2448 HULLY AVE ANGELA E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland	-	artmen <i>rtificat</i>				-	giene Reg. No	2006	Section of the sectio	5623
	Physici /Medio		1. Decedent's Name (First, Middle, Las Sr. Mary Eliza	abeth And		, SND					2. Date of De Month May	Da 1			me of Death
	Examir	ner	4a. Facility Name (If not institution, give 1201 Caton Ave.					timo	Location of the location of th		0. 0		n/a		
	Funeral Director		5. Social Security Number 6. Security Number 218-56-9852	M 2 1 F	ge (In yrs. Ia 74	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Sept.	20,	1931	country)	tate or Foreign
	Maryland	tor	10a. State 10b. County MD n/a		1	Town or Lo									de City Limits Yes 2 □ No
	h with the	Funeral Director	10e. Street and Number 1201 Caton Ave.				10f. Zip		7-101	.2		_	tizen of What C	Country?	
980	be filed within 72 hours after death with the Maryland lai Hygiene. d other then "naturel", or items 23e or 28e-f ehow event. The Medical Examinat must be indiffied at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? (No		Was Deced If Yes, spec 1 Yes		ispanic Ori n, Mexicar Specify:	gin? (Spe n, Pu <i>e</i> rto I	ocity Yes or No Rican, etc.))•	14. Race - Am Black, Wh Specify: Wh	ite, etc.	an,
21215-0036	d within 72 ho giene. ir then "natur i've Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		5+)	life.	dent's Usua kind of wo DO NOT us hool	rk done d se retired	during mos ()	t of workii	ng]	ind of Busines: Teachin Nursing	-	
Maryland	2 should be filed within and Mentai Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last) Walter Anderson								(First, Middle 1cCarth		Sumame)		
	12 = 72 = 72 = 72 = 72 = 72 = 72 = 72 =		19a. Informant's Name/Relationship (7 Sr. Edithann Kane	ም የ ምዕኒince Admin.		305	Cable	Str		Balt	imore,	MD.	21210)	
Baltimore,	age: ent of ent: If y or		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify		C6	ace of Dispo emetery, crei 1top	SVC.	ther plac Corp		5-16-		То	wson, M	laryla	ınd
Balt	permit. P Departm Importer any Injur		21. Signature of Funeral Service Ligen	_		1	1050	York	Roa	d, To	owson,	Mary	uneral /land 2	1204	
	Physician /Medical Examiner	niner	23a. PMr1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, lary leading to immediate cause. Enter Underlying Cause, (Disease or injury)	aSUDDE Due to (or as bDue to or as	ine. N CARI s a consequ AC HYI s a consequ	DIAC D lence of): PERTRO	РНҮ					rrest,		Interva Onset	
,09289	death certificate be executed eattending physician and the for use as the burial-transit	dicai Examiner	that initiated events resulting in death) Last	d				15001		I D Di i	,,,				
P.O. Box 6	that the death certific: ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1	2 Fetal	death 3	Ectopic pi						23d. Date of de Month	elivery Day	Year
	quires that n signed b ald be deta	b	Part II. Other significant conditions of	ontributing to death	but not resu	ilting in the u	nderlying o	ause give	en in Part I	•		obacco Yes 2	use contribute □No 3□F		e of death? 4 Unknown
Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed									24a. Was auto perfo	psy ormed?	prior to death?	completion	dings available n of cause of
f Vital	sician: certific rector,	To Be (25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} = 2 \subseteq \text{No} \)	Hospital: 1 ☐ Inpat	ient 2 🗆 I	ER/Outpatie	nt 3 🗆 D(OA Oth	0.5		(Check only one 5 Resi		6 □Other (Sp	ecify)	
sion of	ding J. After fune		27. Manner of Death 1 Natural 5 Pending investigation	1	ury ay Year)	28b. Time o Injury	f 2	28c. Injun Worl	yat k? Yes 2□		28d. Describe	how inju	ry occurred		
Division	i Diffe	Certification:	3 Suicide 6 Could not be determined	Zoe. Place of II	njury - At ho etc. <i>(Specify</i>	me, farm, st	reet, factor	y, office		2	28f. Location (City or To		nd Number or F e)	Rural Route	Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical		ysician: To the bes niner: On the basis and manner s	of examinat										use(s)
)	To the To the Comp	M	29b. Signature and title of certifier	helit	lla	m			e number 37359				ay 12,		ear)
	3		30. Name and address of person who Kris M. Shekitka 31. Date filod (Month, Day, Year)	, M.D. St		es Hop		1 900) Cat	on Av	ve. Bal	timo	ore, MD	2122	9
	51	ate	MAY 1 8	2006	Sec. 2	All the	1000	B							

		•	1 - For State Registrar	Otate of	iviai ylai i	-	artment of rtificate o				ienę _{ag. Nó.} - 0 0 (15624
	*	Č.	Decedent's Name (First, Midd.	lle, Last)					2	Date of Deat	h Day Yea	3. Time of Death
- 4	Physicia /Medic		Dorys And	lerson					1	May 15,	2006	" 12:50 P M
	Examin		4a. Facility Name (If not institutio	on, give street and numb	oer)		4b. City, Town		of Death		4c. County of D	
			7917 Ruxway Ro	ad			21204				Baltimo	
1	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs.		If Under 1 Year Months Day		Min. 8	Date of Birth (Month, Day,	1 ⁷ 0, 1918	Birthplace (State or Foreign Country) Maryland
	Director		212-03-2439 Usual Residence of Decedent		88	Yrs.				March	10, 1916	Maryiano
	and and		10a. State 10b. County	у	10c. City	y, Town or Lo	ocation					10d. Inside City Limits
	Manyl f sho	ō	Md. Balti	imore	To	owson						1 ☐ Yes 2√ No
	28a	rec	10e. Street and Number				10f. Zip Code	,		10	0g. Citizen of What	Country?
	3a or		7917 Ruxway Ro	oad			2	1204				USA
	death ms 2	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.	Was Decedent of If Yes, specify Co	f Hispanic Or	rigin? (Speci	ify Yes or No-	14. Race - A Black, W	mencan fndian,
ဖွ	after or ite	Ē	1 Never Married 2 Mai	rned 1 Tyes 2	₩ No		1 ☐ Yes 2 [X]N			our, 0.0.,	Specify:	
21215-0036	within 72 hours after death with the Maryland ene. hen "patural", or Items 23a or 28a-f show he Medical Ezenting must be notified at	d by	3 ☑ Widowed 4 ☐ Divorced		es:							
5-(natu	Completed		nt's Education est grade completed)		16a. Dece	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during mo: ired)	st of working	7	16b. Kind of Busine	ss/Industry
12	withir ane. then	E G	Elementary/Secondary (0-12)	College (1-4	4or 5+)		naker	700)			Own Home	
	filed Hygi ther ant,		17. Father's Name (First, Middle,	, Last)		1		18. Moth	er's Name (First, Middle, N	Maiden Sumame)	
an	d be ental ked c	To Be	Charles DeVit	oliss				Marc	querit	e Buck	<	
Maryland	shound M	-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Stre	et and Numb	per or Rural I	Route Number,	, City or Town, State	e, Zip Code)
	alth a alth a 27 th		Mr. Doug Ander	rson/ Son		168	1 Exeter	Road	Westm	inster,	Md. 211	57
ore.	of He of He of He roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval from St		Place of Disponentery, crei	osition (Name of matory or other p	olace)	Dat	te	20c. Location - City	or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show appriants: If item 27 is marked other than "natural; or items 23a or 28a-f show appriantly or other traumatic event, the Mactical Examination and the notified at apprex.		4 Donation 5 Other (Specify) /	Du]		√alley M		5~18-0		Timonium	, Md.
at	Departi Departi Importi eny inj once.		21. Signature of Fun ral Service	Licensee		22	Ruck To	dress of Facil யக்கா F	_{iity} Tunera	l Home.	Inc.	
ш	40 E S 0		M	00			IUDU YC	IR KO.	. IOWS	<u>on, Ma.</u>	21204	1
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To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the bes miner: On the basis and manner:		wledge, death i tion and/or inve	occurred at estigation, i	t the time, n my opini	date and pl ion, death o	lace, and	I due to the cat the time, d	ause(s) a ate and	and man	ner as state nd due to th	ed. e cause(5)
To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	0 1-			29c.	License n	umber		2	9d. Date	signed	(Month, Da	v. Year)	
1		1 Wamps	Shaple	9-		A	000	025	71		2/13	0/2	6		
2		30. Name and address of person who	completed cause of	death (Item	23a) (Type, P	rint)						7			
			10 494		STERN	Ave	NUE	. B.	AZTI	mure	, 0	70 2	122	4	
Stat Registra	۷	31. Date filed (Month, Day, Year) MAY 1 8 2	32. Reg is	trar's Signa	ture Apr	and I									

GARY BRENGLE 06-03107 UNK UNK

Please Type or Print in Black Indelible Ink

NK UNK		∮- For State Registrar	Maryland / Departm Certific	cate of Death	and Menta		eg. No.	006 562
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last) Gary Norman Brengle	e.			2. Date of Dea	Day Year	3. Time of Death 0622 hrs
- \		4a. Facility Name (if not institution, give st		4b. City, Tow	n, or Location of	May 8, 20 Death	4c. County o	
		2100 Block Washington Blvd	. Carol Park	Baltimo	re			N/A
Funeral Director			7. Age (In yrs. last bi	rthday) If Under 1 Months Yrs.	1 Year If Under Days Hours	Min	rth(MM/DD/YYYY) 21, 1967	9. Birthplace (State or Foreign Country) MD
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	٦	MD Carroll		Westminste	r			1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number		10f. Zip Co		1	10g. Citizen of Wh	
th the l 23a or notifie		2231 Coon Club Road			21157		United	
eath wi items	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces?			n? (Specify Yes or No Puerto Rican, etc.)	0- 14. Race White	- American Indian, Black, e, etc.
after de al", or	by Fu	3 Widowed 4 X Divorced If Y	Yes 2 X No Yes, Give Year Dates:	1 Yes 2 X	No specify:		Specify:	White
hours a	ed b	15. Decedent's Education (Specify only I	nighest grade completed) 16a	Decedent's Usual Oc during most of working			16b. Kind of Bus	siness/Industry
36 nin 72 E. Ithan "dieal I	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Constru	-	·	Home I	mprovement
e, MD 21215-0036 I and 2 should be lifed within 72 hours after death with the Maryland Haland Hygien what the man 23 or 28a-f shorten 27 is marked other than "natural", or items 23a or 28a-f short raumatic event, the Medical Examiner must be notified at once	Com	17. Father's Name (First, Middle, Last)			18.Mother's	Name (First, Middle,	 Maiden Surname)
2121; ould be fil Mental I- marked c event, t	Be	Bruce David Brengle			1	Charlene C		
MD 2 d 2 should Ith and M n 27 is m	٤	19a. Informant's Name/Relationship (Type	· · · · · · · · · · · · · · · · · · ·	9b. Mailing Address (505 Zaidee				I
e, MD 1 and 2 sh Health an item 27 i		Bruce D. Breng1e - 20a. Method of Disposition	20b. Place	of Disposition (Name		Date		City or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tra		1 XSurial 2 Cremation 3 Donation 5 Other Specify:	Tromoval monit oldic	atory or other place) on Park Cem	etery	5-12-2006	Baltim	ore, MD
Baltir permit. I Departmo Importa injury or		21. Signature of Funeral Service Ligensee			-	Ambrose F	uneral H	ome, Inc.
	V	Sum Deli	DIV			ry Rd., La		
Physician /Medical		23a. Part I. Enter the disease, or complica failure. List only one cause on each	line.	not enter the mode of d	iying, such as cai	rdiac or respiratory an	rest, snock, or nea	Approximate Interval Between Onset and Death
Examiner			anging e to (or as a consequence of):					Death
· - '		Sequentially list conditions, b						
	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated	e to (or as a consequence of):					
cuted ind	zar	events resulting in death) Last Due	e to (or as a consequence of):					
execut an and al - tra		dd	MENDED					
30x 68760, death certificate be executed and physician for use as the burial	Medical	IF FEMALE:	23c. If yes, outcome of pregnancy	у			23d. Date of	delivery
687 certific ding p	sician/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		pregnancy	Month	Day Year
Box e death of the atter ed for us	ysic	1 Yes 2 No 9 Unknown	9 Unknown	5 Other (Specify)			
O. In the rat the rat by the etacher	by Phy	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the underlying ca	use given in Parl	1. 23e. Did t	obacco use contri	bute to the cause of death?
S, P.C uires that n signed td be deta						- //	s 2 ✔ No 3	
cords law requi has been	Completed					24a. Was	psy p	Vere autopsy findings available in in to completion of cause of
tal Rec sian: The l certificate !	S					1 ✓ Yes		eath? Yes 2 No
ital sician: s certifirector	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 ER/0	26. Outpatient 3 DOA	Other	Nursing Home 5	Residence 6	Other Seese
of V ing Phy After thi uneral d	.: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b		. Injury at Work?	28d. Describe	how injury occurre	
ion feath. for: A	gi	1 Natural 5 Pending 2 Accident Investigation	May 8, 2006 000	00 hrs 1	Yes 2 🗸	No Deceased I	nanged self	
ivisi or At after d Direct	Certification:	3 ✓ Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory, of	ffice building, etc.	. 28f. Location (or Town,		er or Rural Route Number, City
Divi ospital or hours afte meral Dir y filled in	Š	4 Homicide determined 29a. Certifier 4 Certifier Physician	(Specify) Under bridge			2100 Block	Washington	Blvd. , Baltimore, MD
Division of Vital Records, P.O. Box 68760, within 24 hours altor executed. To the Hospital or Attending Physician: The law requires that the death certificate be executed. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ledical	one) 2 ✓ Medical Examiner: Or	. To the best of my knowledge, den the basis of examination and/or					
To To	Med		d manner stated.		icense number			ed (Month, Day, Year)
		Q M	1. 1/4		D.C.M.E.		. 5/8	166
5		30. Name and address of person who com	·				-/-	
				111 Penn Street,	Baltimore, M	D 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Régistrar's Signature	Anastes				
			A STATE OF THE STA					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 05-15-**Physician** MELVIN LEE BURTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL CARROLL HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 152M 2□ F 80 1925 MARYLAND Director 6/11/ 219-10-1093 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "naturel", or iteme 23a or 28a-f show treumstic event, the Middel Examinar must be notified at 1 ☐ Yes 2 ☑ No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ā 21157 495 TREMONT DR., APT. USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. illed within 72 hours after N⊠Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWHITE Year or Dates: WW JI 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PAINTING PAINTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 is marked of RAYMOND JACKSON BURTON MARY ELLEN DAILEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Refationship (Type, Print) 495 TREMONT DR., WESTMINSTER, MD 21157 HELEN BURTON - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Buriaf 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. LAKE VIEW MEM.PARK 5/19/06 ELDERSBURG, MD Donation 5 Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME geral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ed by the ettending physicien and deteched for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ ON CHRONIC RENAL FAILURE 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown ACUTE Completed ISCHEMIC CARDIO MYOPATH 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2/2 No After this certific funeral director, Be 25. Was case referred to medical 26. Pface of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation efter deeth Director: 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30263 05-15-07 200 MEMORIAL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARPOIL HUSPITAL CENTER FRANCIS KHOO WESTMINSTER MD 2115 32 Asistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 8 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	ate of Marylar	•	rtment of F		lental Hygie	0000	15628
H	Physicia	an	Decedent's Name (First, Middle, Last)	Brill				2. Date of Death Month May 1	Day 2006	3. Time of Death
>	/Medic Examin	al	Hattie Elizabeth 4a. Facility Name (If not institution, give street Glen Meadows			4b. City, Town, o	r Location of Death	riay i	4c. County of Death Baltimor	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs.	last birthday) Yrs.	Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb. 19,	9. Birth	nplace (State or Foreign untry) roinia
	פ	tor	Usual Residence of Decedent 10a. State 10b. County Md. Baltimore		ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	with the ta or 28a the noti	Director	10e. Street and Number 11630 Glen Arm Rd.	#14B		10f. Zip Code 21 05	7	10g.	Citizen of What Co	untry?
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Evention must be rediffed at	by Funeral	11. Marital Status 12. V A	/as Decedent Ever in U med Forces? ☐ Yes 2 ☑ No Yes, Give ear or Dates:		1	tispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
1215-0C	within 72 hou ene. then "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occup kind of work done OO NOT use retired istrative	during most of worki d)	ing	Blue Cross	ndustry 3/ Blue Shie
/land z	world be filed Mental Hygin arked other atic event, L	To Be Co	17. Father's Name (First, Middle, Last) William M. Jordan				18. Mother's Name	e (First, Middle, Maid Brown	den Sumame)	
Baltimore, Maryland 21215-0036	l and 2 sho lealth and ! im 27 is ma har traums		19a. Informant's Name/Relationship (Type, F Mr. William Brill/ S 20a. Method of Disposition	on	11 B	-	Rd. Berli	in, Md. 21 Date 200		
imor	permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 is eny injury or other trau		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	.1top S	ervice Co	5-16-		Towson, Mo	
Ba	permit Depar Impor eny in		21. Signature of Funeral Service Licensee			1050 York	son Funera k Rd. Tows	son. Md. 2	Inc. 21204	Approximate
<i>}</i>	Physician /Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Jenus and Jenus Attention List only one cause on each line. Into Order to Control of the C							
o.	that the death certificate be executed aby the attending physicien and detached for use as the burial-transit	Physician/Medical E	in the past 12 months?	yes, outcome of pregn Live birth 2 Feta Pregnant at time of of	ancy	Ectopic pregnancy Other (specify)	y		23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	ed by P	Part II. Other significant conditions contributions from the conference of the confe	s contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of deal 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Un	
of Vital Records,	The law ate hes b page 2 s	Completed by	HP how amp		24a. Was an autopsy performed	prior to o	topsy findings available completion of cause of			
Division of Vit	ath. rr. After this of funeral direction	Certification: To Be	1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor M 1	Nursing Ho y at k? Yes 2 ☐ No	me 5 Residence 28d. Describe how i	njury occurred	
Div	To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the	dical Certif	4 Homicide determined 2 29a. Certifier (Check only) 2 Medical Examiner:	Be. Place of Injury - At he building, etc. (Special: To the best of my kn	owledge, death	occurred at the til	me, date and place,	28I. Location (Stree City or Town, S and due to the caus	e(s) and manner as	stated.
)	To the He within 24 To the Fe completel	Medic	29b. Signature and title of certifier	and manner stated.	ador and or in	29c. Licens		29d.	Date signed (Month	n, Day, Year)
	10		30. Name and address of person who complete M DALY MV) (43)	eted buse of death (Ite	m 23a) (Type,	Print) Charles	Si (Ballino	re M	0 21204
	Sta Regist		31. Date liled (Month, Day, Year) MAY 1 8 200	ated suse of death (Ite 32. Registrar's Sign	ature	porte				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:00 A M May 16. 2006 Margaret Ann Borland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard 8732 Stonehouse Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 27, 1963 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months 1 ☐ M 2 💢 F Director 220-62-1801 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28e-f show any highry or other treumatic event, the Madical Exeminar must be notified at once. 1 Tyes 2 No Director Ellicott City Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 U.S.A. 8732 Stonehouse Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government 4 Cartographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Ruth ပ Bernard Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type, Print) 8732 Stonehouse Drive Ellicott City, Maryland Husband <u>James C. Borland</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 5-17-2006 5 ☐ Other (Specify) Towson Maryland **₩**□ Donation 21. Sign ture of Fineral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21204 Towson, Maryland 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UVARIAN CANCEL **Physician** 6 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consaduence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner anding physician and use as the business To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 9 Unknown 9 Unknown ate has been signed to page 2 should be dete 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by 1 🗌 Yes 27 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 No certificate After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manger of Death 1 Avatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 40 D33409 30. Name and address of person when impleted cause of death (Item 23a) (Type, Print) 10 #YIT, Whentle Ferly Sharfmu 10753 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 8 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UUS Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 10:19 AM MAY 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, BALTIMORE CITY N/A THE JOHNS HOPKING HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 07/11/1944 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min 1 ☑ M 2 ☐ F NY 61 Yre 105-34-9595 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No TOWSON BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 232 BURKE AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 👿 Married WHITE 1 ☐ Yes 2 ☑ No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER WESTINGHOUSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) KRAMER BIALIK TDA LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 232 BURKE AVENUE - TOWSON, MD 21286 CAROLYN WESTBROOK-BIALIK / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stale 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 05/17/2006 OWINGS MILLS, MD

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other than "natural; or Item any injury or other traumatic event, Ite Medical Examinations.

Physician /Medical Examiner

> A E burial-transit

the attending physicien

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, to

Physician/Medical

à

Completed

Be

2

Certification:

27. Manner of Pe

29a. Certifier

(Check only one)

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause (Disease or injury Examiner that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

23a. Part1. shocky

4 Donation 5 Other (Specify) 21. Signature / uneral Service Licensee

. Enter the disease, or corneal List of

1 - For State Registrar

10a State

MD

Physician

/Medical

Examiner

Funeral

Director

or than "natural; or items 23a or 28a-f show the Medical Erandre must be notified 24

Completed by Funeral Director

Be

10

deeth with the Maryland

Baltimore, Maryland 21215-0036

а	Myocardial infarction
J	Due to (or as a consequence of):
h =	Hypertension Due to (tras a consequence of):
D. —	Due to (tr as a consequence of):
. =	
C	Due to (or as a consequence of):

HAR SINAI CEMETERY

IF FEMALE: 23h Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Imonth

10 years

Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chrunic obstructive ?	nlmonary disease
Diahetes mellitus	,

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 1 Yes

22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

3 Probably 4 □Unknown

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 PNo

Hyperlip: de mia 25. Was case referred to medical examiner? 1 Yes 2 No Hospital:

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year, 28c. Injury at Work? 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

1 Cinatural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 \ Homicide

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore MD 21287

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wolfe 400 N. Danie Mana 32. Registrar's Signature 31. Date filed (Month, Day, Year)



Registrar DHMH 17 Rev 1/2001

State

			riease	State of Maryland		nt of Health and M	-	_	
			For State Ragistrar	State of Marytana	-	te of Death		No.2006	15631
			Decedent's Name (First, Middle, L.				2. Date of Death		3. Time of Death
	Physicia /Medic		Bernard Fra	ncis Brooks	Jr		Month 05	Day Year	61310 M
	Examin		4a. Facility Name (If not institution, g	ive street and number)	4b. City	, Town, or Location of Death	1	4c. County of Dea	th
				1edical CONT	er BA	HIMOR &	O Date of Dist	NA	Al -la (Ch.)
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. las	Yrs. Months		8. Date of Birth (Month, Day, Y	ear) 9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	70			10-11-10	13 /	Maryland
	ehow		10a. State 10b. County	10c. City, 7	Town or Location				10d. Inside City Limits 1 Yes 2 No
:	Be-f	Director	Md. W/A	130	altimo				4
:	a or 2	늄	10e. Street and Number	i start		p Code	100	. Citizen of What C	ountry?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		2/2/8 Ident of Hispanic Origin? (S Identify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Am	erican Indian,
9	or item	F.	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No	If Yes, spe	. /	o Rican, etc.)	Black, Whi	te, etc.
3	irai', c	d by	3 ☐ Widowed 4 Divorced	if Yes, Give Year or Dates:		/		Specify:	ack
	illed within 72 hours after deeth with the Maryland Hygiene, then "natural", or Items 23s or 28e-f ehow ent, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education rade completed)	16a. Decedent's Usu (Give kind of we	ial Occupation ork done during most of wor use retired)	king 16	b. Kind of Business	/Industry
7	withir ene. then	Ę,	Elementary/Secondary (0-12)	College (1-4or 5+)	Marke			Distril	cution
2	illed Hygi other	Be C	17. Father's Name (First, Middle, La.	st)			ne (First, Middle, Ma	iden Sumame)	
0	Mental Mental Brked o	To B	Bernard F.	Brooks		Alvin	ria W	Illiam	\$
2	2 should and Men ie marke sumatic		19a. Informant's Name/Relationship		19b. Mailing Addres	s (Street and Number or Ru	ral Route Number, (. 1 .	1
≥ · D	l end lealth im 27 her tr		Sernand F. I. 20a. Method of Disposition	3rooks TLL 20h Plac	514 No.	1-remont	40e, 130	c. Location - City of	Md. 2/201
2	Peges nent of the int: If its iry or of		1 Burial 2 □ Cremation 3	Removal from State	metery, crematory or	other place)	9 6 :		3
Dailino	그 원원등		4 ☐ Donation 5 ☐ Other (Special Service Licenses)	1	rrison to	and Address of Facility	11006 6	wings	MILIS, MO
0	Deperiment of the periment of		Joseph &	· Russ	Josef	orest 3-16 and Address of Facility by L. Russ F 2 w. North	AUD BO	il to more	md 21216
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the death. It one cause on each line.	Do not enter the mo	de of dying, such as cardiac	or respiratory arres		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Larynge	al Cana	er			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):				
П	LAGIIIII	J.	Sequentially list conditions,	b. Respira		rest	 		
	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	AL .					
'n	be execution and purial-tran	Еха	resulting in death) Last	Due to (or as a conseque	ence of):				
-	0 5 0	lical		d					
X 00	requires thet the death certificat sen signed by the attending phy hould be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnance	CV			23d. Date of de	linear.
X D D	eath c atten	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	death 3 □Ectopic p			Month	Day Year
į.	t the d by the ached	hysi	9 Unknown	9□ Unknown					
ι, Γ	es the gned I	by P	Part II. Other significant conditions	•	ting in the underlying	cause given in Part I.			o the cause of death?
cords,	equire sen si ould I	ted	Hyperten.	sion			1 X Yes	2 □ No 3 □ P	robably 4 Unknown
ပ စ	has b	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
	sician: The law cartificate has b irector, paga 2 s		05 W				1 ☐ Yes 22	No 1 □ Ye	s 2 No
VII	s carti	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital: 1. ★Inpatient 2 ☐ EF	R/Outpatient 3 D	Othor	ath <i>(Check only one)</i> Iome 5 ☐ Residen	ce 6 ∏Other (Spe	ecify)
ō	Attending Physician: r death. ector: After this cartific by the funeral director,	 -	27. Manner of Death			28c. Injury at Work?	28d. Describe how		,7
<u> </u>	endin eath. or: Af he fur	atic	2 ☐ Accident investigat	ion	, м	1 ☐ Yes 2 ☐ No			
=	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ne, farm, street, facto	ry, office	28f. Location (Stre City or Town,		lural Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cardific completely filled in by the funeral director.		29a. Certifier 1 Certifying	Physician: To the best of my knowl	ledge, death occurred	d at the time, date and place	and due to the cau	se(s) and manner a	s stated
90	10 Hos	Medical	(Check only 2 Medical Ex	aminer: On the basis of examination and manner stated.	on and/or investigation	n, in my opinion, death occu	irred at the time, date	and place, and du	e to the cause(s)
661	To the within 2 To the comple	ž	29b. Signature and title of certifier		29	9c. License number	290	l. Date signed (Mon	th, Day, Year)
}			Xyndsp	× mD		P19685		May	11,2006
			30. Name and address of person wh	no completed cause of death (Item 2	23a) (Type, Print)	P19685 Greene Str	ant Rai	Lange	18 2 () ()
	C+	ate	31. Dale filed (Month, Day, Year)	32. Registrar's Signatu	ire /	o Regive - 772	ey DAL	minge /V	DAIAUI
	Regist			2006 Alesser A	S. Agran				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

		•	For State of Maryland / Department of Health and W. 1 - State Registrar Certificate of Death		g. No.	15632
1.* B			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	hysicia /Medic	ai	John Crawford As Escility Name (If not institution give street and number) 4b. City, Town, or Location of Death	05	4c. County of Deat	
E E	xamine	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Boltimore		N/A	
Fu	neral	^	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
Dir	ector		251-30-6233 138 M 2 L F 81 Yrs. Usual Residence of Decedent	06/11/1	424	_SC
yland	More Tel		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ■ No
A Mar	Ba-f el	ctor	MD Baltimore Baltimore	10	g. Citizen of What Co	
6,07 AM	a or 2	Funerai Director	1246 North Augusta Ave. 21229	10	us A	unu y :
death G	me 23	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
$\int \mathcal{O}\mathcal{C}$ 1215-0036 within 72 hours after ene.	id other than "natural", or feme 23s or 28s-f enow event, it e Maolical Experimenment be notified at	by Fu	1 Never Married 2 Married 1	,	Spacific ()	acK
/ 06 5-0036 72 hours aff	lical E		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ring 1	16b. Kind of Business/	Industry
2121 ad within giene.	than the Man	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Grade College (1-4or 5+) Truck Driver		Fairlane	
Hygie	ent, II	Be Co			faiden Sumame) UN	1K
laryland 212	arked atic ev	To B				
Mar Mar d 2 sho	Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 1244 North Augusta Ave.			
re, r	tem 2	h	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 2	20c. Location - City or	Town, State
altimore,	int: If I		1 🔀 Burial 2 Ucremation 3 URemoval from State 4 Donation 5 DOther (Specify)	12006	Baltimor	e, MD
Balti Sermit	Important: if Item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee 22, Name and Address of Facility	Funeral	Services	
u aa	.≥ e Q		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Phys	sician		shock, or heart failure. List only one cause on each line.			Onset and Death
/M	edical		Immediate Cause (Final disease or condition resulting in death) a. Bone metastages Due to (or as a consequence of): Sequentially list conditions, b. Cancer of the front all sequences of the control of the properties of the control of the cont	_		_ /24/74
Exa	miner	<u>_</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	2		4) 1/4
uted	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.			
0,	sicien and burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):		•	
68760, ficate be ex	the state of the s	edicai	d			
Box 6	attending p		IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	
\mathcal{FORD} Records, P.O. Box 68760, The law requires that the death certificate be executed	he atte	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Month	Day Year
P.C	ed by I		Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds,	ng sign	ed by	Supra Vinteredas Tructy sourche, Disteles	1 □ Ye	es 2□No 3□P	robably 4 Unknown
FOR Becords,	as bee 2 sho	Completed	millitus hyper insim	24a. Was ar	y prior to	utopsy findings available completion of cause of
A R	cete h			perform 1 Yes 2	No 1□Yes	2 № No
ALL Vital	s certifi irector	o Be	examiner?	th <i>Check only one</i> ome 5 ☐ Reside	e) ence 6 A Other (Spe	KIN HOSDICE
D of B Phy	ter this neral c	 -	27. Manner of Death 1 @Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	100
Sion	tor: Al	catic	2 Accident investigation 3 Surcide 6 Could not be	28f. Location (St	reet and Number or R	ural Route Number.
Division al or Attending	Direc d in by	Certification;	4 Homicide determined building, etc. (Specify)	City or Town	n, State)	
Hospita 4 Pours	To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.			
To the	To the	Mec	29b. Signature and title of Gertifier 29c. License number		9d. Date signed (Mon	th, Day, Year)
	d		> Y/ikar 7. Hayes, mo Doo2298		5/9/06	
4	1		30. Name and address of person who completed cause of derth from 23a) (Type, Print) Wichiel C. HAYES, MD - P 27 Leinden Bre B	salto z	21201	
733		ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature			
	Regist	rar	MAY 1 8 2006 Common St. 199			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:50 AM Clash 2006 Elizabeth MAY 16 Helen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMOR E 9 MD SAINTAGNES HEALTH CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🔀 F 78 Yrs. 216-24-9719 Director MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location worle 10b. County Item 27 is marked other then "natural", or Items 23a or 28e-1 ebov other traumatic event, Tra Moulcal Examinar must be notified at Y☐Yes 2 ☐ No Director NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 U.S.A. 2317 North Rosedale Street Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 5-0036 1 Yes XXNo Specify: Specify. þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mentat Hygiene. 7 Is marked other then "ni 2121 College (1-4or 5+) Elementary/Secondary (0-12) Housewife Home 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be 1 and 2 should be Ruth Cooper ဥ Charles Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any njury or other tra once. 2317 North Rosedale Street, Balto, Md 21216 John Clash-Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Premation 3 Removal from State 4 Propation 5 Other (Specify) 4 Denation Metro Crematory Inc 5/17/2006 Baltimore, Md etur. Funeral Service Licensee 21. Sign 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Par II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARREST **Physician** disease or condition resulting in death) CARDIO-RESPIRATORY /Medical Due to (or as a consequence of): Examiner TO URINARY TRACT INFECTION SEPSIS SECONDARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit SEVERE MOITARAPHSA that initiated events resulting in death) Last Due to (or as a consequence of): 2 2045 Physician/Medical RENAL FAILURE ACUTE IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death ed by the P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 performed? 1 ☐ Yes 2 WO 1 Yes 2 NO Vital Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA ot 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury Division 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide à Ne Hospitel filled i 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asmin Alittamyani, P9154 MD MAY 116, 2006 1/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YASMIN ALI HAMIRANI MOS ST AGNES HEALTH CARE, 900 CATON AVENUE , BALTIMORE, MD, 2123

State Registrar

MAY 1 8 2006

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, per/ID (8855 5/25/06 TT) Department of Health and Mental Hygiene 15634 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 15^{Day} Donald E. Conrad May Month 2006ar 6:58 P M Donald Conrad 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Linthicum Chesapeake Hospice House If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) June 23 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 M 2 □ F Yrs. Pennsylvania 216-24-7367 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 TXNo Maryland | Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 755 214th Street USA 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th electrician construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Robb Ε. Conrad Dortha M 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G Conrad 8242 Green Ice Dr. Pasadena MD 21122 son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery 5/18/2006 Elkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Se 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) Mitastati disease or condition resulting in death) Due to (or as a consequence of): Saquardially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hope 1 🗌 Yes 2 NO 27. Manney Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Physician Examiner Division of Vital Records, P.O. Box 68760

sicien and burial-transit The law requires thet the death certificate be executed the attending physicien as the ō detached ል this: filled in by the funeral To the Hospital or Attending Pl within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral

Physician

/Medical

Examiner

Director

by Funerai

Completed

Be

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Examiner

Physician/Medical

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Completed

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Certification:

Funeral

Director

-how

item 27 is marked other then "neturel", or items 23a or 28a-1 show other treumsite event, the Medical Evand, or must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or iten eny fijury or other treumatic event, the Mudical Expri

/Medical

Baltimore, Maryland 21215-0036

the Maryland

With

death

State Registrar

Kristophe

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

deBoria 3708 mountain Rd Pasadera mol 2/1/22 32. Registrar's Signature

MAY 1 8 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** CARRIGAN 4:50 AM WILLIAM MAY 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL CENTER N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 22,1947 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 218 46 5084 59 Yrs Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Marvland Anne Arundel **Baltimore** Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 306 Arundel Road West U.S. 21225 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nenf of Health and Mental Hygiene. Int: ff Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Clerk 6+ years Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Carrigan Melva Mackin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colleen Adams / sister 306 Arundel Road West Baltimore, Maryland 21225 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page. Department o Important: ff Elkridge, Maryland Meadowridge Mem. Pk. 5/19/2006 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. any. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pari 1. Enter the direate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List or ty one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) CANCER LUNG **Physician** YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be execute the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 1 Yes ₽ No 1 TYes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: Certification: To 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1-Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES OOI MAY, 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar RAGHAD JALIL

2006

31. Date filed (Month, Day, Year)

ORIGINAL

frank

32. Registrar's Signature

3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 0417 A M Carter 15 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Cit 14 Hospita 8. Date of Birth (Month, Day, Year) Dec 14 1996 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F 9 213-49-5975 Yrs Md Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Eldersburg 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at Carról1 Md 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 1054 Pebble Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status e filed within 72 hours after all Hygiene. 1 Yes 2 TNO
If Yes, Give A
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) student education permit. Pages 1 end 2 should be file Department of Health and Mental Hy important: if item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jennifer A. Stassi Bill Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1054 Pebble Ct., Eldersburg, Md 21784 19a Informant's Name/Relationship (Type, Print)
Mr. Bill Carter (father) 20b. Place of Disposition (Name of cemetery, crematory or other place)
All County Cremation 5-20-06 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Sykesville, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Duan Litarist P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death dilated cardiomyopathy **Physician** /Medical Due to (or as a consequence of): Examiner -B cell Acute lymphocytic M Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physicien and detached for use as the burial-translt immunadetitiena Common variable Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be Bronchiolitis obliterans 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown preumona Completed has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Bone marrow transpiant this certificate Renal insufficia 1 ☐ Yes 2 X No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Mnpatient examiner? Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending i Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funeral To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) elso, no RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Baltimore, MD Kriska Nelson, no 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			30. Name and address of	of person who co	moleted cause of dead	h (Ham 23a) (Tu	ne Print)	10000	1277	/	May 16, DCIRS He	2006
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4c,perMD,g857,7/20/06 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. U 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 05.06. 2006 2:10 ELSIE M. DOW /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NURSING GLEN BURNIE MARINER FACILITY Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year Hours Days 1 ☐ M 2 🔀 F Yrs. 10.05.1924 Director 220. 22. 6169 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Iteme 23a or 28a-f ehow the Mydical Examiner must be notified at 1 Yes 2 No BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA ROAD 104 ROLLNOVIEW 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 NWidowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 te marked other than " Elementary/Secondary (0-12) College (1-4or 5+) BALCO UNIFORM SEAMBIRESS 12/H GRADE NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CHARLIE BARNEY PEARLIE BARNEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (DAUGHTER) 9720 BROWN RD. JONESBORO, GA CLARMHA NICHOLS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department Important: If eny injury or ODGS. 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS 05.12.06 BAUTO. MD 21. Signature of Funeral Service License 22. Name and Address of Facility FUNERAL SERVICE Vaugh 5151 BALTO. NATU PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a END STAGE RENAL FAILURE **Physician** /Medical Due to (or as a consequence of): **Examiner** b. ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed CORONARY ARTERY DISEASE Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) 4 Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe ARTERIOSCLEROSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy certificate has 1 ☐ Yes 2 No Attending Physician: After this certific funeral director. 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Oate ol Injury (Month, Day Year) Certification: 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certi-ALINGARE on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe PATALINGHUG SRAD 32. Registrar's Stanature 31. Date liled (M

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19b, perFb (857 7/18/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** DEZWART 04:08PM LIAM 16 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARBOR HOSPITAL CENTER 8. Date of Birth Month, Day, Year, 1943 If Under 1 Year Months Days 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours 62 Mary land Director 215-42-8785 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be nutified at MD Baltimore **Baltimore** 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 21227 2914 Vermont Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. d 2 should be filed within 72 hours after in the and Mental Hygiene. It is marked other than "naturel", or iter traumatic event, the Medical Examiner. 1X Yes 2 ☐ No 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes X No Specify: Specify 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Master Electrician Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Dezwart Eleanor Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Meyers item 27 i 2914 Vermont Ave., Baltimore, MD 21227 Daughter 20b. Place of Disposition (Name of Westmel Arthrec's or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2X Cremation 3 Removal from State Ξ Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Crematory 5-18-2006 Odenton, MD 21. Signature Funeral Service Licensee 22. Name and Address of Faciliambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician DAYS disease or condition resulting in death) /Medical DUODENAL LILCER **Examiner** ERFORATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed COHOL that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown DISEASE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No certificete has 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number RES mo 000 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SUN HANOVER STREET, BALTIMORE, MARYLAND XIAOGUANG 31. Date filed (Month, Day, Year) WAY 1 8 2006 32 Registrar's Signature Registrar

06-03261 Willie Daniels Please Type or Print in Black Indelible Ink
of Maryland / Department of Health and Mental Hygiene

ille Daniels		1- For State Certificate of Death Reg. No. 2 1 6	1564
Physicia edical Exami	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	e of Death 25 hrs
edical Exami		4a. Faolity Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral		Sinai Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MMyDD/YYYY) 9. Birthplace ((State or
Director	1	23 -88-7159 1 XM 2 F 47 Yrs. Months Days Hours Min. 5/20/58 Foreign Country)	lirgini
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ath with th items 23a	neral D	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 1 Never Married 2 Married 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India. White, etc.	ian, 8lack,
hours after de "natural", or	Ω.	3 Widowed 4 Divorced If Yes, Give Year or December 1 Yes 2 No specify: Specify: Specify: 16b Kind of Business/Industry	d
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	16 Illie Daviels SR Lena Kandall	,
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Examiner		or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	
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ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be execut reteath. retors. After this certificate has been signed by the attending physician and we the trins certificate has been signed by the attending physician and we the funeral director, page 2 should be detached for use as the burial—tran	Physician/M		Year
D. Bo the deat by the at	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca	ise of death?
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Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in be	Medical Co	1 29d. Utilities 4 A set it is Because in To the heat of multipowledge death occurred at the time date and place and due to the cause(s) and manner as started	e(s)
To wit	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day O.C.M.E. May 15, 2006	y, Year)
		30 Name and address of person who completed cause of death (Item 23a)	
		Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Regi	State		

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			For State Registrar				Ce	rtificate of	Death			g. No	006	100	L} [
П	Physicia	an	1. Decedent's Nam	•						2. Dat Mo		Day	Year	3. Time of I	
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36	rs afte		1 Never Mari	ried 2 Married 4 □ Divorced	1 XYes If Yes, Giv Year or Da	rces? 25%54 ates: 5/	56	1 ☐ Yes 2012 No	Specify:			S	pecify: Wh:	ite	
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Mary	id 2 shoulth and M		19a Informant's N Kevin Dal					ng Address (Street Sycamore				-		Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than, insturat, or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐Cremation 3	☐Removal from	20b. State Mai	Place of Dispo cemetery, cre	osition (Name of matory or other place Veteran C nsville	emete	Date	2	0c. Loca	ation - City or To	wn, State	
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)36 urs aft	l', or	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 A Yes 2 ☐ I If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:		Specify	. Whi	te
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E Page	nt; if i		1 ⊈Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec				em. Park 5/	17/2006	Elkridg	ge, Ma	aryland
Baltimore,	partm ports y inju		21. Signature of Funeral Service Lice		1				uneral Se		
m 8.	Depar Impor any ir once		germe Zow	minger	H;	4001 R	itchie High				land 21225
- 1			23a. Part1. Enter the disease, or continuous, or heart failure. List on	nplications that caused y one cause on each li	the death. Do no	t enter the mode	of dying, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
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Divisi	after o	Certification:	4 Homicide determine	building, et	jury - At home, farn tc. <i>(Specify)</i>	n, street, ractory,	, οπισε	City or T	(Street and Numb own, State)	er or Hura	Houte Number,
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 1:24 A^M 15, 2006 May Benjamin Franklin Dean /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 10706 Westcastle Place Apt. T4Cockeysville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country)
 VA 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 1920 10, 85 June Director 225-01-5149 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Marical Examines must be notified at 1 ☐ Yes 2 No Director MD **Baltimore** Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21030 10706 Westcastle Place Apt. T4 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 38 1-80 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 Officer Military 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Georgia Hoy Benjamin Franklin Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5382 Viewpoint Ct. Eldersburg, MD 21784 Benjamin Franklin Dean, III/Son 20b. Place of Disposition (Name of Duraney Valley Memorial Gardens May 22, 20c. Location - City or Town, Stete 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 Timonium, MD ^¹ 4 □ Donetion 5 □ Other (Specify) 21. Signature of Fun ral Service Licensee Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 once Bryán Clary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latitude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a c Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetel death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s autopsy perform 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 2 2 ER/Outpatient 3 DOA this After this 27. Menner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation within 24 hours after use....
To the Funeral Director: After the funeral in by the fu М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 33 ar 30. Name and address of person-who completed cause of death (Item 23a) (Type, Print) E. Padonia Road Timonium, MD 21093 Albert DiGerolamo 35 3 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

8 2006

Amend Item: 17 per F.H G-855 5/18/06 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year C. Dickerson John 530 05 2006 /Medical 4b. City, Town, or Location of Death Buffiners 4a. Facility Name (If not institution, give street and number) 4c. County of Deaph Examiner University of Many hard 5. Social Security Number 6. S Meliul Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 108 M 2□F 215-40-1207 Usual Residence of Decedent Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at 2008. 1 Yes 2 □ No Md altimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 nan Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) aborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Motley Misline 19a. Informant's Name/Relationship (Type, Phint/ Drother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place) Baltimorend, 21216 St. Mr. Gordon KIL 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State UT. ZION Cemetery 5-20-2006 hansdowne 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Concer Hepatocellulur I mo th /Medical Due to (or as a consequence of) Examiner Hegestitis B Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit teprotitis 5 years Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached for 9 Unknown 9 Unknown signed | d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Circhasis 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Heroin Abusa, rmed? 2 X No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 1 ☐ Yes 2 ☑ No Medical Certification: To 1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this Director: After that in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) P16480 May 13th, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grance Beltimore md 21201 So. HL 54. 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19a per 1h 8855 5-26-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 5 **Physician** 2006 2:25 a. 14 Evans Herbert .Terome /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Balto Future Care If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-20-1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 T F Μd 82 Director 217-18-0180 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 Yes 2 □ No Balto N/A Md Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 104 W. Franklin Street Apt 508 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Bfack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 🗓 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) American Standard Elementary/Secondary (0-12) College (1-4or 5+) Foundry Radiator N/A12th grade 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If item 27 is marked other by Injury or other treumatic according 17. Father's Name (First, Middle, Last) Bright Cora Mae Lewis Herbert Evans 19a. Informant's Name/Relationship (Type, Andrews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto, Md 21201 774 W. Dr. Ben Quarles Place Clyde Evans Adareus 💶 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5-19-2006 Balto, Md Baltimore National *4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licer see 22. Name and Address of Facility March F/H West Mome hompan Wabash Avenue Balto, MD 21215 4300 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** LENEBCO VASCULAR Accident /Medical Due to (or as a consequence of): **Examiner** In known Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION Due to (or as a consequence of) Examine univar Hypercholestrolena Due to (or as a consequence of): Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Month Year in the past 12 months?
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1 Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident 28c, Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Division of Vital Records,

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To the Hospital

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sals

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29c. License number

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14/06

			For State Registrar	State of	Marylan		artment of H	lealth and N Death		giene Reg. No. 0	06	15646
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "satural; or Items 23s or 28s-f show any injury or other traumatic event, the Medical Expriting minut for colling at once.		21. Signature of Funeral Service L		-,		. Name and Addre		once Fur			
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			1 - For State Registrar	State of Marylar		artment of I		nd Mental Hy	giene	6 15647
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	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
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Baltimore,	permit. Pages 1 and 2 Department of Health is Important: if Item 27 I any injury or other tra		20a. Method of Disposition 1 Durial 2 Cremation 3 Re	moval from State	cemetery, cren	sition (Name of matory or other pla		Date	20c. Location - City	or Town, State
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	/Medical Examiner		resulting in death)					Frede	7 ./	2 days
H		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec		sw/a		TECICLE	ent	7 days
	nd the ransit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events							
9	death certificate be executed et ettending physicien and et der use as the burial-transit	i Ex	resulting in death) Last	Due to (or as a consec	quence of):					
68760	physicate to physicate to the control of the contro	dicai	d.							N.
Box	eath certific ettending r for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregn		75			23d. Date of	delivery
	e death he ette ned for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		Ectopic pregnanc Other (specify) _	;y 		Month	Day Year
<u>о</u>	that the de ned by the e detached		9 ☐ Unknown Part II. Other significant conditions confi	inbuting to death but not res	sulting in the ur	nderlying cause or	ven in Part I.	23e, Did t	obacco use contribut	e to the cause of death?
Vital Records,	The law requires that the site has been signed by the sage 2 should be detache	ed by								Probably 4 Unknown
ဝင္ပ	e law rec has bee je 2 sho	Completed						24a. Was		autopsy findings available to completion of cause of
<u> </u>		Сош							rmed? death	ገ?
	Physician: Th this certificete ral director, pag) Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	ospital:	I SD/O	ot ot		of Death (Check only o		
ō	- E	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	1 JU DON	4 🗆 14013	sing Home 5 Resident	dence 6 Other (S	Specify)
Sior	Attending Firdeath. ctor: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(World, Say Your)	injury		Yes 2 N	0		
Division of		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)	eet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	r Rural Route Number,
)	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier 1 = Certifying Physics (Check Culy 21) Medical Examin	ician: To the best of my kno ef: On the basis of examina	owledge, death	occurred at the ti	me, date and	place, and due to the	cause(s) and manner	r as stated.
1	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens				
	Z × Z		3 2/20	weine	No			!	29d. Date signed (M	
•	12		30. Name and address of person who cor	npleted cause of death (Iter	m 23a) (Type, I	Print)	-//	732	-//	/ 3
	-			eine mo	21	West	RD	12001	on Me	021204
ASI	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 200	32 Aegistrar's Signa	ature A	well .	,			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 75 Goble Alden Jack /Medical 4c. County of Death 4b. City. Town, or Location of Death Eacility Name (If not institution, give street and number) Examiner Rosedale Baltimore ware HosoHa ranklin. | HUNDER | Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 20, 1940 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Kentucky 1**X** M 2□ F Yrs. 65 220-34-7287 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryfand or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Nottingham Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 21236 18 Virginia Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 👿 Married 1 ☐ Yes 2 X No Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "navy Injury or other traumeth." Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive 9th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fred Goble Vivian Dutton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean A. Goble (Wife) 18 Virginia Avenue, Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holly Hill Mem. Gdns. 05/20/2006 Baltimore. Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ardiomyopath P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 4 Unknown 3 Probably 1 □ Yes 2 □ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No certificate 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Certification: To 20 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending n 24 hours after death.
he Funeral Director: After pletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🎷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Pay, Year) 30. Name and adure s of person who completed cause of death (Item 23a) (Type, Print 32 Registrar's Signature 31. Date filed (Mo State Registrar

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hyglene.
Important: If item 27 is marked other then "netural", or items 23a or 28a-f ehow eny Injury or other traumatic event, the Madical Experiment is used.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CUADI DO		r T C					Month May	Day 16,	Year 2006	5:09 p M
CHARLES	tution, give street and number		4h City	Town or	Location	of Death	Мау		y of Death	
		,		ırel	Location	or Douth			•	orge's
602 Montgomer 5. Social Security Number		ge (In yrs. last birthd		r 1 Year	if Under	24 Hrs.	8. Date of Birth			place (State or Foreign
217-28-1899	1□M 2□F	72 Yrs	Months	Days	Hours	Min.	(Month, Day, July 2,	_{Үөаг)} 1933	Cou	yland
Usual Residence of Deceder										7 - 4 - 4
10a. State 10b. Co	unty	10c. City, Town o	r Location		-					10d. Inside City Limits
Maryland Pri	nce George's	Laurel								1 Xyes 2 □ No
10e. Street and Number			10f. Zip	Code			10	g. Citizen of	What Cou	intry?
602 Montgomer	y Street #2		2	0707				U.S.A		
11. Marital Status	12. Was Deceden	t Ever in U.S.	13. Was Dece	dent of H	ispanic Ori	gin? (Spe	cify Yes or No-			ican Indian,
1XXVever Married 2□	Marned Marned Marned Marned Marned	No 1952					Rican, etc.)		ick, White	, etc.
3 ☐ Widowed 4 ☐ Divo	orced Year or Dates	-1956	1 ☐ Yes	21 X X 0	Specity:			Speci	^{fy:} Wh	ite
	edent's Education lighest grade completed)	16a. De	ecedent's Usu	al Occupa	ation	t of worki	1	6b. Kind of E	Business/Ir	ndustry
Elementary/Secondary (0-		- lit	e. DO NOT	ise retired) ')	i or worm	''9			
Grade 12			ndow C	Clean	er			Window	v Cle	aning
17. Father's Name (First, Min	ddle, Last)				18. Mothe	er's Name	(First, Middle, M	a <i>ide</i> n Suma	me)	
Sylvester Gal	lis				Ann	a Bo	ndra			
19a. Informant's Name/Rela	tionship (Type, Print)	19b. M	lailing Address	s (Street a	and Numbe	er or Rura	al Route Number,	City or Towr	, State, Zi	p Code)
Elizabeth A.	Dwyer / Per	. Rep. 640	4 Fore	est M	ill I	ane	Laurel,	Mary	Land	20707
20a. Method of Disposition		20b. Place of Di	isposition (Na.	me of other plac	e)		ate 2	Oc. Location	- City or T	own, State
1 ☐ Burial 2 <u>X X</u> Crema 4 ☐ Donation 5 ☐ Oth	tion 3 □Removal from State er <i>(Specify)</i>	West Aru	-			5/18	/2006	Odento	on, M	aryland
21. Signature of Funeral Se	vice Licensee		22 Name at	nd Addres	ss of Facilit	yra 1	Home, P.	7\		
GR	/ MO	0770					Laurel		land	20707
23a. Part1. Enter the disease	se, or complications that cause List only one cause on each	ed the death. Do not	enter the mod	de of dyin	g, such as	cardiac o	or respiratory arre	st,		Approximate Interval Between
Immediate Cause (Final	\	oral Thron								Onset and Death Minutes
disease or condition resulting in death)	a	s a consequence of):								112114 000
	Mali	nant Lymp								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of):								
	1									
resulting in death) Last	Due to (or a	s a consequence of):								
	d									
	12-814									
IF FEMALE: 23b. Was decedent pregnar		e of pregnancy 2 Fetal death	3 ☐Ectopic p	10000000				23d. D	ate of deliv	rery
in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of death	5 Other (s					М	onth	Day Year
9 ☐ Unknown	9□ Unknown						-			
Part II. Other significant co	nditions contributing to death	but not resulting in th	e underlying	cause give	en in Part I		23e. Did tob	acco use con	tribute to	the cause of death?
	uctive Lung D	isease					1 ☐ Yes	2 □ No	3 🗌 Pro	bably 4 🛣 Unknown
Chronic Obstr							24a. Was an		Were aut	opsy findings available
							autopsy	ed?	prior to co	ompletion of cause of
25. Was case referred to me	edical				26 Place	of Dooth	1 Yes 2 1 (Check only one	Ŋ No	1 🗌 Yes	XXNo
examiner?	Hospital:	ient 2 ☐ ER/Outpa	atient 3 Do	Cth			me 5 N Resider		hor /Casa	6.1
	28a. Date of In	ury 28b. Tim		28c. Injury Work			28d. Describe how			197
1XXNatural 5 ☐ P 2 ☐ Accident in	ending (Month, D vestigation	a <i>y Year)</i> Inju	ry M		<br Yes 2□	No				
3 ☐ Suicide 6 ☐ C	ould not be elemined 28e. Place of le	njury - At home, farm	, street, factor	y, office			28f. Location (Stre		ber or Rur	al Route Number,
4 ☐ Homicide	building,	etc. (Specify)					City or Town,	State)		
	tifying Physician: To the bes	t of my knowledge, d	leath occurred	at the tim	ne, date an	d place,	and due to the car	use(s) and m	anner as s	stated.
29a. Certifier 1 2 6e (Check only 2 Men	fical Examiner: On the basis and manner s	of examination and/o	r investigation	n, in my o	pinion, dea	th occurr	ed at the time, da	te and place	and due t	o the cause(s)
	ertifier /		29	c. License	number			d. Date sign		
→/////	14///	1		1)	30	ill		Man	, 1 -	7, 2006
30. Name and address of pe	erson who completed cause of	death (Item 23a) (Ty	pe, Print)	<u> </u>	U				1	7000

Registrar

State

William Warren, M.D.

31. Date filed (Month, Day, Year) MAY 1

Laurel, Maryland

321 Prince George Street

32. Registrar's Signature

06-03264 Gertrude Griffin

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

icitado Cimin	F	Registrar	tificate of			g. No. 20	06 156
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Gertrude Griffin		-	2. Date of Death Month May 15, 20		3. Time of Death 0108 hrs
viedicai Examir		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Location o		4c. County of Death	
		Good Samaritan Hospital		Baltimore		N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lat 213-52-5676 1 M 2 XF 57	st birthday) Yrs.	If Under 1 Year If Under Months Days Hours		2 1040 Foreig	thplace (State or gn untry) MD
aux		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	on			10d. Inside City Limits
<u>*</u>	٦	MD N/A Bai	ltimore				1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e Street and Number 3229 E. Baltimore Street		10f. Zip Code 21224	10	g. Citizen of What Coul USA	ntry?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 'item 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	Fune	11. Marital Status 1 XNever Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced if Yes, Give Year or Dates.	If Ye	Decedent of Hispanic Origons, specify Cuban, Mexican, Yes 2 X No specify:		White, etc.	ican Indian, Black,
nours a	d be	15. Decedent's Education (Specify only highest grade completed)		's Usual Occupation (Give lost of working life. DO NOT		16b. Kind of Business/I	ndustry
136 hin 72 l e. than "r edical E	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 9th N/A	Н	ousekeeping		Hospita	al
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	B B	17. Father's Name (First, Middle, Last) William Griffin			s Name (First, Middle, M Mildred	laiden Surname) Smith	
e, MD 2121 I and 2 should be f Health and Mental item 27 is marker r traumatic event,	٩	19a Informant's Name/Relationship (Type, Print) Laverne Griffin-Walters-daught	er 322		re St. Balt	imore, MD	21224
늘 ♡ 등 늘 말				tion (Name of cemetery, er place) Prial Park	Date 5/19/2006	20c. Location - City or Randallst	
Baltimo permit. Page Department o Important: injury or oth	Ì	21. Signature of Funeral Service Licensee		ame and Address of Facility	MARCH FUN	ERAL HOME-I	
Physician	-1	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter th	Ol E. North le mode of dying, such as c	Avenue Balt ardiac or respiratory arre	imore, MD est, shock, or heart	21202 Approximate Interva
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Convertive heart Due to (or as a consequence of	failure				Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	"):				
uted Id iansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.):				
760, frate be executed physician and the burial - transit	Medical	kunpended amended item#23a,	,27,per,m	e,G857,7/12/06	II		
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fet	tal death 3 Ectopio	c pregnancy	23d Date of deliver	y Day Year
La e m	F.	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in Pa	art I. 23e. Did to	bacco use contribute to	the cause of death?
, P.(res tha signed be det	d by				1 Yes	2 No 3 Prol	oably 4 Unknown
of Vital Records, ling Physician: The law requir After this certificate has been s funeral director, page 2 should	Completed				24a. Was a autop: perfor	sy prior to o med? death?	utopsy findings available completion of cause of es 2 No
Vital Rechysician: The this certificate	BeC	25. Was case referred to medical examiner?		26 Place of Death	(Check only one)		
Division of Vital Records, P.O. Box 68: ral or Attending Physician: The law requires that the death certifins after death. "I Director: After this certificate has been signed by the attending lied in by the funeral director, page 2 should be detached for use as	은	examiner? 1 Ves 2 No Pospital: 1 Inpatient 2 Ves 27. Manner of Death 1 X Natural 5 Pending	ER/Outpatient 28b. Time of Ir		? 28d. Describe h	Residence 6 Othe	n
digina di Si	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	ome, farm, stree	et, factory, office building, et		Street and Number or Rutate)	ural Route Number, City
Divi To the Hospital or within 24 hours afte To the Funeral Dir	ledical Ce	29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination a	ge, death occur ind/or investigat	red at the time, date and plation, in my opinion, death oc	ace, and due to the caus courred at the time, date	e(s) and manner as star and place, and due to the	ted. ne cause(s)
To with	Med	and manner stated (29c. License number O.C.M.E.		29d. Date signed (Mo	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item Susan Hogan MD. Assistant Medical Examiner		ın Street, Baltimore, I	MD 21201		
	tate		ire	A n			
Regis DHMH 17 Rev 1/2		MAY 1 8 2006 Januar St	ORIGINA	I			
Dinini I/ Nev 1/2			VI VIOLINA	_			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 2:42 P M Mav 15 2006 Francine Mary Rose Gahagan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2 Harlow Court Cockeysville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F May 15, 72 1934 Marvland 219-30-6896 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h Counts in than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21030 2 Harlow Court Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or Item any Injury or other traumatic avent, the Medical Examples Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify white Specify. þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 12 4 Cohen's Clothiers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sadina Pavone William P. Espev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Henderson Hill Court; Monkton, MD 21111 Kathy Allen daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dulaney Valley Mem Gardens Timonium. MD 21. Signature of Funeral Service Unger 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Immediate Cause (Final metria 4801 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b director, page 2 s 1 Yes 2 No or Attending Physician: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending death. 1 Yes 2 No investigation Director: 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire To the Hospitel stated. Providing Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature it title of certifier 29d. Date signed (Month, Day, Year) 5/16/2006 D30929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1. Carlos Street BATTMAN ND 21204 6569 31. Date filed (Month, p Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May Month **Physician** 15 2006 08:00 a M Dorothy N. Garda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2525 Pot Spring Rd. K-209 Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jamon 18 3, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 88 Yrs. 6. Sex 9. Birthplace (State or Foreign South Carolina **Funeral** 1 □ M 💥 F 249-24-7472 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner country. 28a-f show Md. Baltimore 1 Yes 2 No Timonium Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2525 Pot Spring Rd. K-209 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Claims Clerk Rail Road Retirement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jady F. Griggs Louise Smi th 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Donald Garda/ Husband 2525 Pot Spring Rd. K-209 Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify: ntombment Dulaney Valley Mem. 5-17-06 Timonium, Md. 21. Signature of Furieral Sprvice Licenses 22. Name and Address of Facility Funeral Home: 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebra /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine sician and signal stransit The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 2 Yes 2 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑(No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 1 Yes 2 2 No ospital or Attanding Physician: To hours after death. uneral Director: After this certificate by filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗷 Natural 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 / Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI May SZ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 D Road, Valley Imonium MD 21093 Wrig 2300 Dulaney = Mesting 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 2006 Registrar

		1 - For State Registrar	State of Maryland / D	epartment of H Certificate of I		lental Hygiei Reg.	ZUUb	15653
		Decedent's Name (First, Middle, Last)		-		2. Date of Death Month	Day Year	3. Time of Death
Physici /Medio		Valerie	Hart				2 2006	11:18AM
Examir		4a. Facility Name (If not institution, give str	reet and number)	0.110	Location of Death		4c. County of Death	Coty
		0000	7. Age (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth	Baltimore	ace (State or Foreign
Funeral Director			1 0000	rs. Months Days	Hours Min.	(Month, Day, Ye	SG MARY	try)
		Usual Residence of Decedent				19/0//		
show		10a. State 10b. County	10c. City, Town				10	od. Inside City Limits 1 Yes 2 No
ith the Ma or 28a-f s	Director	MD. N/A	BALT	IMORE				
		10e. Street and Number 6014 MARJORIE LI	٧.	10f. Zip Code 212	12	10g.	Citizen of What Coun USA	try?
72 hours after death w neturel; or items 23a	Funeral		2. Was Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - America	an Indian,
I fler d	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.
Paris a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 22 Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: BLA	CK
72 hc	Completed	15. Decedent's Educa (Specify only highest grade		Decedent's Usual Occup (Give kind of work done of	during most of worki	ing 16b	. Kind of Business/Ind	lustry
vithin Den	Пр	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired IV SPECIALIS	*	A	MERICAN RE	D CROSS
Hygie thert	e Co	17. Father's Name (First, Middle, Last)				e (First, Middle, Maid		011000
d be d be ced o	To Be	MILTON HART			н∆тттг	ROBINSON		
2 should be filled within and Mental Hygiene. Is marked other than aumatic event. the Mental Hygiene.	-	19a. Informant's Name/Relationship (Type	e, <i>Print</i>) 19b.	Mailing Address (Street			ty or Town, State, Zip	Code)
and 2 ealth a m 27 ls		LEONARD HART(SON)	1.	30 AUSTIN DI	R. MT. WO	LF, PENNA	17347	
of He of He rothe	-	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	cameten	Disposition (Name of y, crematory or other place		Date 20c	. Location - City or To-	wn, State
permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre ance.		*4 □ Donation (Specify)	ENTOMBMENT MOORE:	LAND CEMETE		2006 BAI	LTIMORE, M	ARYLAND
permit. Departi Import any inj pnce.		21. Signature of Funeral Service Licenses					•	
2 205 4 4		23a. Part . Efter the disease, or complic		1721-27 N.			MORE, MARY	Approximate
		sho k, or heart failure. List only one	cause on each line.					Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Metastati Due to (or as a consequence of		oma ot	-The pr	-6021	
Examiner			Due to (or as a consequence of	и).				
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):				
cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events c.						
ate be executed hysician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	of):				
ate thys	dical	d.						
w requires that the death certific we ensigned by the attending p should be detached for use as	Completed by Physician/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy				23d. Date of deliver	ry
atten atten for u	clan	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1			Day Year
the d	hysi	1 Yes 2 No 9 Unknown	9□ Unknown					
s that	y P	Part II. Other significant conditions cont		the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
require een sig	Pe	Diabetes Me	ellitus			1 🗆 Yes	2 No 3 □ Proba	ably 4 Unknown
as be	plet					24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
The The ate ha	E O					performed 1 ☐ Yes 2,区	? death?	2 No
cian: cian: ertifica	Be (25. Was case referred to medical examiner?		04		h (Check only one)		
Physi Physi I this c	2	1 Tes No	ospital: 1 Inpatient 2 ER/Out		4 Nuising no	me 5 Residence 28d. Describe how in	6 Other (Specify)
ding Ith.	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. T	njury Wor	yai k? Yes 2 □ No	200. Describe now ii	njury occurred	
death death ctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, far building, etc. (Specify)			28f. Location (Street	and Number or Rural	Route Number,
after Dire	erti	4 Homicide	building, etc. (Specify)			City or Town, Si	tate)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge	, death occurred at the tin	ne, date and place.	and due to the cause	e(s) and manner as st	ated.
he Ho in 24 he Fu pletek	edical	(Check only 2 Medical Exeminone)	er: On the basis of examination and and manner stated.					
To t To t	Σ	29b. Signature and title of certifier	20	29c. Licens	e number	29d.	Date signed (Month, L	Day, Year)
		Jromas SC	N GEZUN	1740	0411	J Y	1914)	2006
		30. Name and address of person who con	1	Type, Print) Loch Rai	1010 1	101 R-1	LIMARIER	MD 2.13 20
	ate	Thomas S. W. (50) 31. Date filed (Month, Day, Year)	Registrar's Signature	a rain	0-N121	vu isal	MANIONE	110 -1259
Sta Regist		MAY 1 2 2836	Marine 18 1	Escap 1				

			1 - For State Registrar A	MEND ITEM	State of M F5 PER F.						Mental H	ygien Reg. N	20	06	15654
	Physici /Medio		Kelli	(First, Middle, Last	Irvin	e					2. Date of D Month MAY	15	ay 20	-	3. Time of Death Dille PM
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	Funeral Director		5. Social Security N 224-06-0	umber 6. Se 566	х 7. Ag	10 (In yrs.	last birthda Yrs.	/) If Un Mont	der 1 Year	If Under 24 Hi Hours Min		ay, Yea	r)	·	place (State or Foreign ntry)
	yland		Usuat Residence of 10a. State	10b. County		10c. Ci	ty, Town or	Location						1	0d. Inside City Limits
	8a-f e	ctor	MD	Anne Arun	nde1		Glen B	urni	e			,			1 ☐ Yes 2 ☒ No
	with the	Dire	10e. Street and Nur						Zip Code				itizen of W	hat Cour	ntry?
	eme 23	nera	11. Marital Status	ive	12. Was Decedent Armed Forces?	Ever in U	I.S. 13		21060 cedent of H	lispanic Origin? ((Specify Yes or Norto Rican, etc.)				an Indian,
21215-0036	be filed within 72 hours efter death with the Maryland tal Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral Director	1 🗌 Never Marri 3 🗆 Widowed	ed 25 Married 4 Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:				2½ No	Specify:	sito i sioan, etc./		Specify:	k, White, Wh	ite
15-(n 72 h "natu	iete	(Spec	15. Decedent's Edu ify only highest grad	cation le completed)		16a. Dec	edent's U	sual Occup work done	ation during most of w	orking	16b.	Kind of Bus	siness/In	dustry
212	d withi	Completed	Elementary/Seco 8	ndary (0-12)	College (1-4or 5	5+)		ner	use retired	.,		W	eldin	g Co	mpany
pu	be filed tal Hygi d other event,	Be	17. Father's Name							18. Mother's Na	ame (First, Middl				1 7
Maryland	d 2 should be th and Menta the marked treumatic ev	ှင	Leo F. In	TVINE Ime/Relationship (7)	(De Print)		19h Mai	lina Addr	es (Stroot		nnie M. Rural Route Num			Danas 7:-	0.41
	Tan Tan			F. Irvin							Burnie,			state, ∠ip	Code)
Baltimore,	Ser		20a. Method of Disp	position		20b. F	Place of Disponentery, cri	osition (/	Name of or other place	(e)	Date		Location - (City or To	wn, State
<u>ti</u>	Pag men ant:		1 🖾 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clen Haven Mem. Park 5-19-2006 Glen 21. Signalur, Fineral Service License 1 Service License 1 Service License 2 Serv									en Bu	rnie	, MD	
Ba	permit. Departr Imports eny inji		21. Signatury Filher Service Line Hold ((22. Name and Address of Facility Singleton 1 1 Second Ave SW; Glen Burn 2 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre-									nie	neral , MD	Hom 2106	e, PA 1
			23a. Pårt1. Enter ft shock, or hear Immediate Cause (trailure. List only of	ications that caused ne cause on each lin	the deat	h. Do not e	Α.		*		arrest,			Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)		Due to (or as	one	ary	145	per	gillos	15	_			
	Examiner		Sequentially list con	nditions	Respir	ate	0r4	Fail	ure						
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گ	execu en and rial-tra	Exar	that initiated events resulting in death) L		Due to (or as	a conseq	uence of):								
68760,	tificate be executed go by the side of the surjection and as the burial-transit	edicai			d										
	eath certific attending p		IF FEMALE: 23b. Was decedent	pregnant 2	3c. If yes, outcome	of pregna	ancy						Old Date	of delive	
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Vital Records,		Completed									24a. Was auto perf 1 Ves		pri	or to con	psy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be c	25. Was case referrexaminer?		lospital:				Othe		eath Check only				
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sior	Attending r death. actor: After by the fune	catio	1 Matural 2 Maccident 3 Maccide	5 Pending investigation 6 Could not be			Injury	М	10	res 2 □ No					
Division of	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	4 Homicide	determined	28e. Ptace of Injubulation building, etc.	:. (Specif)	v) 				City or To	wn, Stati	θ)		Route Number,
	the Hosp in 24 hot the Fune ipletely fi	Medical	29a. Certifier (Check only one)	1 ☐ Certifying Phys 2 ☐ Medical Exami	sician: To the best of ner: On the basis of and manner sta	examina	wledge, dea tion and/or in	th occurre ivestigati	od at the tim on, in my op	e, date and plac sinion, death occ	e, and due to the urred at the time,	cause(s date an) and mani d place, an	ner as sta d due to	ated. the cause(s)
\	To the within 2 To the comple	≥	29b. Signature and	title of certifier	By in				9c. License				ite signed (-
	12		30 N m and addr	ss of person who	moleted cause of de	aath (Ito-	23a\ /Tunn	Print	P196	85			MAY	1/5	2006
	10,		31. Date filed (Month	sey Ce	XIMD		, 23a) (Type	010	RthC	Leene !	Street	BAL	timu	re.	2006 MD 21201
3	Sta Registra		MAY		2. Registra	u s signa	Some	D							

TRVING, Kelly LED

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** /Medical or Location of Death 4c. County of Death Examiner MOFQ Jnder 24 Hrs. 8 Age (In vrs. last birthday) Date of Birth Month, Day, Birthplace (State or Foreign
Country) **Funeral** Days Min 1□ M 2XF Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic avant, the Medical Examinar must be notified at 1 es 2 No Director IMOR 10e Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 6501 Itams 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Tho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Department of Health a Important: If itam 27 is any injury or other tra Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IVET CANCER - Ampullary adenocarcino **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2-No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice ို 1 ☐ Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Anatural 2 ☐ Accident 5 Pending death. investigation after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number D 58303 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

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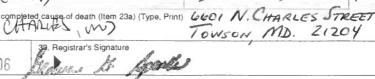
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ARRON 31. Date filed (Month, Day, Year) 8 2006

J.



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2-006

MAY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 📖 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Jones 11.10 M Ellen MAY 2006 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Johns Hopkins Borview Medical Center If Under 1 Year II Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 💢 F Director 220-18-5737 4-27-26 80 Md Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location wor 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examination and once. 1 XYes 2 No Baltimore Directo Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 633 N. Aisquith St. Apt. 10-D USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give — Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Custodian Hoschild Kohn N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gamble James Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6333 Boston Street, Baltimore, Md. Grafton Jones Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings, Mills, Md. 5-17-06 Garrison Forest Vet. 21. Signature of Funeral Service Lickns 22. Name and Address of Facility Baltimore, Md. 21202 pose March F.H. East 1101 E. North Ave. 23a art1. Enter the disease, or complications that dayled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im sdiate Cause (Final discription or Sulting in death) Physician Septic Shock /Medical Due to or as a consequence of): Examiner associated preumonia ventilator Sequentially list conditions, it any, leading to infriedlaticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Intracerebral bleed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been siç , page 2 should b Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🕅 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2% No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Medical Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Anu L Manledi, PD KES-000 May 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ami Mankodi. 4940 Eastern Avenue Ballinore MD 21224 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 8 2008 Registrar

			1 - For State Registrer	State of M	laryland	/ Depa		of H	ealth a		lental Hyg	•	06	156	57
			Decedent's Name (First, Middle, Las	t)							2. Date of Dea	th		3. Time of	Death
Н	Physici /Medic		James J	akubowski							May	Pay	2006	4:31	Рм
	Examin		4a. Facility Name (If not institution, give	street and number	")		4b. City, T			of Death			ty of Death		
			631 Ross Drive						ıdena			A1	nne Ar	undel	
	Funeral		5. Social Security Number 6. Se 216-42-0436	x 7. A ⊋M 2□F	ge (In yrs. lasi	birthday) Yrs.	If Under 1 Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day March	Year)	9. Births	lace (State o	r Foreign
	Director		Usual Residence of Decedent	^	64	113.					March 2	8 1942		MD	
	yland		10a. State 10b. County		10c. City, T	own or Lo							1	0d. Inside Ci	ty Limits
	a-f et	ţċ	Maryland Anne Ar	undel				Pasa	adena					1 ☐ Yes	2 🛛 No
	or 28	lre	10e. Street and Number				10f. Zip (Code			1	0g. Citizen o	f What Cour	ntry?	
	23a	rai	631 Ross Drive						1122				USA		
	er deg	ne	11. Marital Status	Was Deceden Armed Forces	t Ever in U.S.	13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		ace - Americ lack, White,		
36	s afte	y Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 DXYes 2 ☐ If Yes, Give Year or Dates:		1	1 🗆 Yes 2		Specify:			Spec		ite	
8	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or fleme 23a or 28a-f ehow ent, the Medical Evaluar med be notified at	Completed by Funeral Director	15. Decedent's Ed			6a. Dece	dent's Usual	Occupa	tion		1	16b. Kind of	Rusiness/in	dustry	
212	n nin 72	piet	(Specify only highest grad			(Give	kind of work DO NOT use	k done di e retired)	uring most	t of worki	ng			,	
21	giene giene	E O	12	4	34)		Archi	tect	,				Design		
nd	al Hy d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		•		
<u>ya</u>	Men Men Marke	2	James Jakubow							lian	_	olajczy			
Maryland 21215-0036	12 sh h and 7 ie m traum		19a. Informant's Name/Relationship (7								I Route Number	-	n, State, Zip	Code)	
	1 and Healt tem 2		Sharon E. Jakubo 20a. Method of Disposition	wski (spc	20b. Plac	e of Dispo	sition (Name	e of			ena, MD	21122 20c. Location	- City or To	wn. State	
<u>o</u> E	ages ent of nt: If if		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify				natory or oth emator) C	May 20	16 F	altimo			d
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, it a Medical Exaction inval be notified at once.		21. Signature of Euneral Service Dicenter				. Name and	•			allings				
ä	Departiment of the permit of t		1 My 1.8			4	3111 1	Moun	tain	Road	Pasac	ena M	10 211	e, r.a 22	•
			23a. Part . Enter the usease, or comp shock, or heart faure. List only of	li ations that cause n cause on each	d the death. (line.	Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	Hups	dens	ine	ر ('س	(4)	PAVO	ديار	er die	ه دیمه		Onset and D	eath)
	/Medical Examiner		resulting in death)	Due to ra	s a consequen	ce of):						15.4			
	- Adminici	<u></u>	Sequentially list conditions,	b. Due to (or a	s a consequen	co of):							_		
	uted insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	240 10 (01 4	a consequen	08 01).									
Ċ.	ires that the death certificate be executed signed by the attending physicien end doe detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequen	ce of):									
		cai	(d											
39	ing ph	Med	IF FEMALE:												
ĝ	ath ce ttend or use	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom- 1☐Live birth	2 Fetal de	ath 3□	Ectopic pre						ate of delive	,	'ear
.O. Box 68	the de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	at time of death	າ 5[Other (spe	city)					101101	Duy .	out
مَ	that I	P.	Part II. Other significant conditions co	ntributing to death	but not resultin	ig in the ui	nderlying car	use givei	n in Part I.		23e. Did tol	pacco use co	ntribute to th	e cause of de	eath?
Records,	uires n sign lid be	d by	DiAbeta	Mell	itus						1 □ Y	s 2 No	3 Prob	ably 4 □U	nknown
Ö	s been si	lete	Manadi	acolomo	1 10						24a. Was a	n 24b	. Were auto	osy findings a	variable
æ	hysicien: The law his certificate has t I director, page 2 s	Completed	- tisker,	poecii	Y						autops perforr	y negr?	prior to cor death?	npletion of ca	use of
<u>ta</u>	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 yes 2 No 9 Unknown 9 Unknown 1 yes 2 No 9 Unknown 9 Unknown 1 yes 2 No 3 Probably 4 Unknown 1 yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performer? 1 yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 yes 2 No 1 yes 2 N														
<u>></u>	Physic this ce al direc	To E	examiner?	Hospital: 1 ☐ Inpat	ient 2 🗆 ER	/Outpatien	t 3 DOA	Other	r: 4 🗆 Nui	rsing Hon	ne 5 Reside	nce 6 🗆 O	ther (Specify)	
ē O	ing Pl		27. Manner of Death ∫ SNatural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28 ay Year)	b. Time of Injury	28	c. Injury Work	at ?	2	8d. Describe ho	w injury occu	irred		
Sio	tendi Seath, tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				М		es 2 🗆 N						
Division of Vital	무 분 분 교	Certification:	4 Homicide determined	286. Place of In	ijury - At home itc. <i>(Specity)</i>	, farm, str	eet, factory,	office		2	8f. Location (St City or Town		ber or Rura	Route Numb	er,
	spital		29a. Certifier Certifying Phy	sicien: To the best	t of my knowle	dge, death	occurred at	t the time	e, date and	d place, a	nd due to the ca	use(s) and n	nanner as st	atéd	
	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exemple)	iner: On the basis of and manner s	ot examination	and/or inv	estigation, i	in my opi	nion, deat	h occurre	ed at the time, da	ate and place	, and due to	the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier				29c.	License	number		2	9d. Date sign	ed (Month, I	Day, Year)	
	. 1		Most mas	M.D.			D	114	72	1		5.15	06		
10	1		30 Name and address of person who c	ompleted cause of	death (Item 23		1			7	1	Δ.Ω ') ,,,		
	-0:		31. Date filed (Month, Day, Year)	30 Baniet	rar's Signature		onuter	102	K	149	r gent	MM)	U1177	•	
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DH	MH 17 Rev 1/20	001	= 0 2000	Jan Carlotter	20 A	N. Carlotte									

ORIGINAL

				State of Maryla					•	oie.
			1 - For State Registrar		Ce	rtificate	of Death		Reg. No. 20	06 15658
	Physic /Medi		Decedent's Name (First, Middle, Last	Robert L.	Johnso	n, Sr.	•	2. Date of Dea Month May	Day	3. Time of Death 9:00 A. M
	Exami		4a. Facility Name (If not institution, give	·		4b. City, T	own, or Location of [4c. County o	
			6431 St. Phi11 5. Social Security Number 6. S.	-	s. last birthday)	If Under 1	Linthicum			ne Arundel
	Funeral Director			x M 2□F 62	Yrs.			Min. (Month, Da Oct. 13		9. Birthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Anne Ar	unde1	Linthic	um				1 ☐ Yes 2X No
	or 28	O Le	10e. Street and Number			10f. Zip (10g. Citizen of W	hat Country?
	s 23s	ra	6431 St. Phill		11.0		21090	2/0- / //	U.S.	4
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decede If Yes, specif		? (Specify Yes or No Puerto Rican, etc.)		- American Indian, , White, etc. White
2-0	72 ho natur	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual	Occupation	f working	16b. Kind of Bus	iness/Industry
21	nen. hen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		$\frac{DONOT}{C}$ emp $1c$	done during most or e retired)		Bar Rest	-aurant
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an	d be ental ked o c eve	To Be		t S. Johnson				ewell Bass	Walder Surraine	/
ary	2 should be filed v and Mental Hygie is marked other t raumatic event, III	1	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Addr <i>e</i> ss (Street and Number of	or Rural Route Numbe	r, City or Town, S	tate, Zip Code)
	1 and 2 Health a tem 27 is		Linda Johnson /	wife	6431	St. I	Phillips R	Road Lint	hicum, N	Maryland 21090
ore			20a. Method of Disposition 1 Burial 2 Cremation 3		. Place of Dispo cemetery, cres	sition (Name matory or oth	e of ner place)	Date	20c. Location - C	ity or Town, State
Ē	nit. Pages partment of i cortant: if its injury or o		4 □Donation 5 ☑ Other (Specify	15/2006	Baltimor	e, Maryland				
Baltimore,	permit. Pages 1 a Department of Hea Important: if item eny injury or othe		21. Signature of Funeral Service Licen	minound.			Address of Facility tchie Hig	Gonce Fun hway Balt	eral Ser imore, M	vice, P.A. aryland 21225
			23a. Part1. Enter the disease for companies of companies of the companies	olications that caused the de one cause on each line.	ath. Do not ent	er the mode	of dying, such as ca	rdiac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Lung	C	aucer			Onset and Death
	/Medical Examiner		resulting in dealth)	Due to (or as a cons-	equence of):					,
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):					
P	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
7,0	e be executêd /sicien and e burial-transit		resulting in death) Last	Due to (or as a cons	equence of):					
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89 x	The law requires thet the death certificate tie has been signed by the ettending phy age 2 should be detached for use as the	Physiclan/Medl	IF FEMALE:	00. 16						
Вох	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1□Live birth 2□Fe 4□Pregnant at time of	ntal death 3	Ectopic pred			23d. Date Mont	of delivery h Day Year
P.O.	by the detached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	deam 3L	1 Ottler (spec	City)			
	s thet ned b e detz	by Pł	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cau	use given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ğ	w requires been sign should be		Grabelles Mel	litus_			 _	1 🔯 Y	es 2□No 3	☐ Probably 4 ☐ Unknown
of Vital Records,	e law requ has been je 2 shouli	ompleted	typelina	em's				24a. Was a autop	an 24b. We	ere autopsy findings available or to completion of cause of
œ.		Соп	0,					perfor	med? de	ath?
/ita	ilcian: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	t la anitali			T	Death (Check only or	18)	
of	Phys this aldii	ဥ	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatien			ng Home 5 PResid		
	ding After fune	to Fo	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	M 280	c. Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describe n	ow injury occurred	
Division	Attending in death. ector: After by the funer	flca	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, str			28f. Location (S	treet and Number	or Rural Route Number,
	s afte s afte bi Dire	Certification:	4 Homicide determined	building, etc. (Spe	cify)	Í		City or Tow	n, State)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Example	rsician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	n occurred at vestigation, in	t the time, date and p n my opinion, death o	lace, and due to the o occurred at the time, o	ause(s) and manr late and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of gertifier	119-			License number		9d. Date signed ((Month, Day, Year)
				J. M.			D 3/322		5	111/06
·	4		30. Name and address of person who co		em 23a) (Туре, 716 М	Print) ADS/	VCHOICE	cv, Ca	1072 VILLA	111/06 E, m) 21228
	Sta Registi	State 31. Date filed (Month, Day, Year) 32 Registrar's Signature								

			1 - For State Registrar	State of Ma	aryland		artmen rtificate			and M		giene Reg. No.2	006	15659
18 7)	Physici	an	1. Decedent's Name (First, Middle, Last)								Date of Dea Month		Year	3. Time of Death
	/Medic		Geza L. Kovac								May	15,	2006	4:40 PM
	Examir	er	4a. Fecility Name (If not institution, give s Long Green Center	street and number)			* .		Location o			4c. Cou	inty of Death N/A	
		\$ 5	5. Social Security Number 6. Sec	7 40	a /In ves Is	ast birthday)	If Under		If Under		8. Date of Birt	2		place (State or Foreign
	Funeral Director		212-34-2341 X	M 2□F		73 Yrs.	Months	Days	Hours	Min.	Nov 28,	1932	Cana	ntry) da
ž.			Usual Residence of Decedent											
	how		10a. State 10b. County		10c. City	r, Town or Lo								10d. Inside City Limits 1 XYes 2 □ No
	8a-f	cto	Maryland N/A			Bal	timor							
	with th	Funeral Directo	10e. Street and Number				10f. Zip	212	10			-	of What Cou	
	s 23a	erai	115 East Melrose	12 Was Decedent	Ever in 11	S. 13.1	Was Deced			ain? (Sa	activ Yes or No-		Canada	
	fler d	Fun	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐	No.	J. 10.				, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	etc.
036	al', o	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1	1 🗆 Yes :	2 Z No	Specify:			Spe	ecity: Wh	ite
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Madical Examinar musi ke notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation campleted)		16a. Deced	dent's Usua kind of wo	al Occupa	ition fu <i>rina m</i> os	t of worki	ina	16b. Kind o	of Business/fr	dustry
21	dthin han	npi	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us					£7.	D.1	0 1 1
121	Hygiei Hygiei Her th		17. Father's Name (First, Middle, Last)			Bus	sines	SEX			e (First, Middle,			n Control
Maryland	2 should be filed within 7 n and Mental Hygiene. 'ie marked other than "r reumatic event, the Med	Be c	Louis Kovacs								lalazs	walson bar	namo)	
Z	Should Me Me Mark	10	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a			al Route Numbe	r, City or To	wn, State, Zij	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at		Ernest Kovacs, Bro	other		33 Wa	arren	ton 1	Road	Balt	imore,	Maryl.	and 21	210
re,	the standard of Head		20a. Method of Disposition			lace of Dispo	sition (Nan	ne of			Date		on - City or T	
E	Pages nent of I ant: If Its		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	ro Cr	emato:	ry I	nc.	-				Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is sny Injury or other tre		21. Signature of Funeral Service Ligens Thomas Gregor	90		22	Crema 299 F	tion rede	SOC1	ety Road	Of Mary	land	Inc. Maryla	nd 21228
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that caused	d the death							,	KIL Y LG	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	11.00	Tole	Sch	soil							Onset and Death
1	/Medical		resulting in death)	Due to (or as	a consequ	uence of	<u> </u>							
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	ed sit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Die to (or as	a consequ	ience oi):	*							
	sate be executed obly sicien and the burial-transit	xar	that initiated events resulting in death) Last	Due to pr as	a consequ	ience of):								
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9	ifficati g phy es the			V										
Вох	endin r use	N/N	23b. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pr	egnancy				23d.	Date of deliv	*
	es that the death certifics igned by the attending pl be detached for use es t	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown			Other (sp						Month	Day Year
P.0	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions con	atabuting to death h	out not resu	Uting in the u	ndarkina o	01100 0111	e in Dod I		23e Did to	bacco use o	contribute to t	he cause of death?
S	law requires that the death certificate be executed es been signed by the attending physicien and 2 should be detached for use es the burial-transit	1 by	Parti. Other significant conditions con	and any to do a tre	/ut 1101 1030	alling in the u	i idenying c	ause give))	•				pably 4 Unknown
Ö	w requir been si should	etec									24a. Was a			
Records,	The lay	Completed									autop perfor	sy med2	prior to co death?	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	CO	25. Was case referred to medical						26 Place	ol Death	1 Yes		1 🗆 Yes	2 No
Ξ	Ø 50	To B	examiner? 1 ☐ Yes 2 ☑ No	lospital:	ent 2 🗆 I	ER/Outpatier	nt 3 DC)A Othe			me 5 Resid		Other (Specia	(v)
υot	문 등 편		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date ol Inju (Month, Da	iry v Year)	28b. Time of	f 2	8c. Injury Work			28d. Describe h			
Ö	Attending r death. ector: After by the fune	atle	2 Accident investigation				М		res 2 🗆	No				
Division	el or Att s after d if Direct id in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et			eet, lactory	r, office			28l. Location (S City or Tow		umber or Run	al Route Number,
	To the Hospitel or Attano within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	f examinat	wledge, death tion and/or in	h occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, th occurr	and due to the deed at the time, o	ause(s) and late and pla	manner as s ce, and due to	stated. or the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and.	10		290	License	number	, ,	à	9d. Date si	gned (Month,	Dey, Year)
	1		Mispory Ce	elly 1	11)			1)4	16	HH		Low	4 17	2004.
r.	, Y		30. Name and address of person who co	impleted cause of c	leath (Item	23a) (Type)	(Print)	- 1	Nn	7	001	1	1 1	
1)		82/12 Eella	10 510e	W	1501	line	ne	171	2	101			
8	Sta Regist		31. Date liled (Month, Day, Year) MAY 1 8 200		rar's Signat	ture	المثالة							

State of Maryland / Department of Health and Mental Hygiene

				Otato or inc	aryland /	-	ficate of	Death		Reg. No. 2	106	15660
	Physici /Medic		1. Decedent's Neme (First, Middle, Le Charles Wil		า				2. Date of Dec May 1	6 2006	Year	3. Time of Death 3:55 P
	Examir		4a. Fecility Neme (If not institution, giv Holly Hill Mand	e street end number))Y			4	4b. City, Town, or Lo LOWSON	ocation of Deeth	4cgCount	illore	County
	Funeral Director		213 37 0173	ex 7. Age ADM 2□F	67		f Under 1 Year Ionths Deys	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat Aug 22	, Year)	9. Birthpla Count Mary	ace (State or Foreign (V) Land
	fand		Usual Residence of Decedent 10e. State 10b. County		10c. City, Tov	vn or Locati	ion				10	d. Inside City Limits
	Mary B-f ah	tor	Maryland n/a		Parkv	ille						1☐XYes 2☐No
	or 28	jrec	10e. Street end Number				10f. Zip Code			10g. Citizen of		•
	23a	rai	2704 Kildaire Dri				21234			United		
020	s 1 end 2 should be filed within 72 hours efter death with the Maryland I Health and Meniel Hygiene. I Health and Meniel Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f ahow other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ₩ bivorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:			S Decedent of Hes, specify Cube	tispanic Origin? (Spe en, Mexicen, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e	
5-0	72 hc natur dical	eted	15. Decedent's Ed (Specify only highest gre	lucation de completed)	16a	Decedent	s Usuel Occup	eation during most of worki	ing	16b. Kind of B	usiness/Indu	ıstry
121	end 2 should be filed within a aalth and Mentel Hygiene. n 27 is marked other then "r ier traumatic event, tre Ned	Completed by	Elementary/Secondary (0-12) 12 years	College (1-4or 5 2 vears	+) D		NOT use retired Office:			City of	Rol+i	imoro
d 2	filled v Hygie ther t		17. Father's Neme (First, Middle, Last)		, , ,	OTICE	OTTICE	18. Mother's Name				TIOLE
lan	d be entel ced o	To Be	John Kurth					Florence		The second second	,	
ary	shou and M american	-	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing A	Address (Street	end Number or Rura	al Route Numbe	r, City or Town,	Stete, Zip (Code)
Σ	1 end 2 Health a em 27 is		Kimberly Gray (d	aughter)				Dr. Balt:	imore, l	Marylan	d 212	234
Baltimore, Maryland 21215-0020	permit. Pages 1 en Depertment of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify				on (Name of bry or other plea Cemete	ery 5-	Date -20-200	20c. Location 5 Balti		
Balt	permit. Depertr Imports any inj	21. Signettie of Funeral Service Licensee 22. Name and Address of Feci McCully-Polynia J. Wayne Osterling 130 E. Fort Ave 23a. P. rt. Enter th. disease, of complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.								ome, P.	A.	
-	Physician	111	23a. P. rt1. Enter th. disease, or composhock, or heart failure. List only	olications that caused one cause on each lin	the death. Do	not enter th	ne mode of dyin	ng, such as cardiac c	or respiratory er	rest,	2.50	Approximete ntervel Between Onset and Death
1	/Medical Examiner		Immediate Ceuse (Final disease or condition	e. Athor	seler	stiz	(and.	o sas cul	in d	Bease		5 Yrst
	Lamine		resulting in death)		Due to (or es a							
ii.	hed nosit	Examiner	•	b			, ,				i	
2	rtificete be executed ng physician end ses the buriel-trensit	Еха	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	'	Due to (or es e	consequen	ice of):				1	
68760,	ite be iysicia he bui	Medicai	Cause (Disease or injury that initieted events resulting in death) Last	c	ue to (or as a	consequen	ce of):				- 40	
39	artifice ing ph e es t		resulting in deathly cust								1	
Box	eath ce ettendir I for use	Physician/		0.								
	tt the de by the e	ıysic	Part II. Other significant conditions co	ontributing to death bu	t not resulting	in the under	rlying cause giv	en in Part I.				the cause of death?
, P.O	es that tigned by	by Pt							101	'es 2□ No	3 Proba	ibly 4⊠Unknown
of Vital Records,	aw requir is been s 2 should	Completed b							24a. Was a perfor		avail	e autopsy findings lable prior to pletion of cause eath?
Œ	The ete h	Com							1□ Y	es 2⊠No	10	Yes 2E No
/ita	i cia n: T certificel rector, p	Be	25. Was case referred to medical exeminer?	I.I. and it.			Tau	26. Place of Death	(Check only or	ne)		
of	is is	T0	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospitel: 1 Inpatier		utpatient 3	3 DOA Oth	4 E Nursing Hor				
5	ding h. After fune	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)	Year)	Injury	28c. Injun World M 1 □	k? Yes 2 □ No	28d. Describe h	ow injury occur	90	$dist_{O(p)_{k}} \ll D$
Division	al or Attending Piselfer death. I Director: After tisel in by the funere	fica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, fa				28f. Location (S		er or Rural I	Route Number,
5	s efter	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or Tow	n, State)		
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	edicai (29a. Certifier (Check only one) 1 ✓ CertifyIng Phyone) 2 ☐ Medical Example 1	ysician: To the best of liner: On the basis of and manner stat	examination ar	e, death occ nd/or investi	curred at the tim igation, in my op	ne, date and plece, e pinion, death occurre	end due to the co ed et the time, d	ause(s) end ma ate and place,	nner as stet and due to t	ed. he cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	our Kiry	0 ,		29c. License		2	9d. Date signe		
	,		•	/	100	6		865-			118/06	
	H		30. Name end eddress of person who o	completed cause of de	eth (Item 23a)	(Type, Prin	t)	B	at mos	m.	(21	2-2/
	Sta	te	R 20 6 31. Date filed (Month, Day, Year)	2. Registra	r's Signature	1 1	street			C 11.0		/
	Registr		MAY 1 8 2006	Fig. Car	13 16	1934Ch						

DHMH 16 Rev 6/95

Charles William Kusta

State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2006ar Eileen E. Lazar 17, May 8:15 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing & Rehab Prince George's Hyattsville 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 3, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number **Funeral** Months Days 1□ M 🎾 F Hours 059-30-7251 68 Director July Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or itams 23a or 28e-f show the Modical Experience ust be notified at 1 ☐ Yes 2√2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3210 N. Leisure World Blvd. Apt-311 20906 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filad within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Supervisor Employee Benefits permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any light or other treumatic event sone. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael J. White Ann E. Swift 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Lazar, Husband 3210 N. Leisure World Blvd. Apt.311 Silver Spring MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation _5 ☐ Other (Specify) Metro Crematory Inc. + 05/18/06 Baltimore, Maryland 21. Signature of Funeral Service Livensee
Thomas Gregor 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician GASTMIC ARGNOMA disease or condition resulting in death) 1 year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): physician sthe burial Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy fo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☑ Unknown page 2 should pieted been 24b. Were autopsy findings available prior to completion of cause of death? autopsy Com performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 \ Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D WB Quelusbury Rel Hyattsu, It MD 20051 DEVORE IN 31. Date filed (Month, Day, Year) 32. Registrar's Si State Registrar

			1 - For State Registrar	State of Maryla	nd / Departme	ent of Health and ate of Death	-	ne2006	15662
1	Physici	an	1. Decedent's Name (First, Middle, Last) Joaq wm D.	Lee			2. Date of Death Month	Day Year	3. Time of Death 8:47A M
2	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s	treet and number) LACE HOSPH 7. Age (in yrs	al Contr. 1	Town, or Location of Deat OCOLOGO der 1 Year If Under 24 Hrs is Days Hours Min.	B. Date of Birth (Month, Day, Yg	2 2004 4c equity of Death DQ 1+1 M ar) 9. Birthp Cour	ACC (State or Foreign
	• Maryland	ctor	10a. State 10b. County NA	10c. C	ity, Town or Location Baltin	10ne		1	0d. Inside City Limits 1 XYes 2 □ No
	ath with the 23a or 28 ust be no	Funeral Director		1 Avenue		Zip Code 21206	10g.	Citizen of What Cour	itry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heath and Mantal Hygiene. Depertment of Heath and Mantal Hygiene. Important: If tem 27 ie marked other than "natural", or iteme 23a or 28e-f ehow any follury or other traumatic event, it a Musical Exacidina must be notified at once.	þ	11. Marital Status 1 Never Married 2	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerlos 250)	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-(id within 72 h giene. er then "netu i II.e Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	work done during most of wo	nking 16b	Educa	•
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, ILE Mi	To Be C	17. Father's Name (First, Middle, Last) Reginald Lee	•		Marga		liver	
1	1 and 2 sh Health and em 27 le rr ther traum		19a. Informant's Name/Relationship (Typ. Margaret B. Lea	e/Mother	48131		ienne Bo	uto. MI	21206
Baltimore,	permit. Pages 1 and 3 Depertment of Health Important: If Item 27 any Injury or other tra once.		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 Real Donation 5 Other (Specify)	emoval from State	Place of Disposition (I cometery, crematory)	t qe D5.	22.00 Pi	Location - City or To Kesville	MD
Bal	permit. Depertr Imports any Inji		21. Signature of Funeral Service License	suo	23. Name 4105	and Address of Facility C. Green TONE ROAD	sureral s Bultimore	envices MD 2121	2
	death certificate be executed Ray Manual Bartending physicien and and as the burial-transit d for use as the burial-transit	Icai Examiner	23a. Part1. Enter the disease, or compile shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	quence of): Alcoho	s encephal	opathy 11-11 S		Approximate Interval Between Onset and Death
P.O. Box 68	that the death certificate be execuined by the attending physicien and detached for use as the burial-tran	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 □Ectopic			23d. Date of delive Month	ry Day Year
rds, P.	w requires that been signed by should be deta		Part II. Other significant conditions con	nbuting to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
al Records,	Physician: The law requires that the this certificate has been signed by the trid director, page 2 should be detached.	Completed by					24a. Was an autopsy performed 1 Yes 2 1	prior to con death?	osy findings available inpletion of cause of
of Vital	ysiclar s certil	To Be	25. Was case referred to medical examiner? 1	ospital: 1 Inpatient 2	ER/Outpatient 3□	Other	th Check only one ome 5 Residence	6 DONNO (C)	1
	Attending Physic death. ector: After this by the funeral di		27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in)
Division	To the Hospital or Attending Ph within 24 hours atter death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)		28f. Location (Street City or Town, Sta	ate)	
	To the Hoepital or A within 24 hours after To the Funerel Directompletely filled in by	Medical	one)	cian: To the best of my known ar: On the basis of examination and manner stated.	ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To To COT	2	29b. Signature and title of certifier	the.	M.P.	PES 500	29d. [Date signed (Month, E	Day, Year)
	3	•	30. Name and address of person who con	th 9000	Franklin	Square Dr	ive Balti	more M	d 21237
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 8 2006	32. Registrar's Sign	ature	į.			

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year MAY 02:55PM ELIZABETH LANDRUM 16 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE AGNES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 2 X X Yrs. Director **79** 212-24-8822 8-17-1926 SC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at Director 1 X es 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 727 MILYER LANE 21229 Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Importent: If Item 27 is marked other i eny injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLAYTON SAMUEL ETHEL McDANIELS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE B. LANDRUM/HUSBAND 727 MILYER LANE BALTIMORE, MARYLAND 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE VET.CEM. 5-23-2006 CROWNSVILLE, MD of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCAR DIAL Physician INFARCTION DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHRONIC RENAL PAILURE 1 Yes 2 No 3 Probably 4 Monknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hoepital within 24 hours a To the Funeral E completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier The destroying Privatean. To the destroin by knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Muntys, M.D. P-17610. MURTAZA KAZMI, ND 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURTAZA KAZMI, NO ST. AGNES HOSPITAL. 900 S. CATON AVE. BALTIMORE. ND 21229 31. Date filed (Month, Day, Year) 32/Registrar's Signature State MAY 1 8 2006 Joseph Registrar

			1_ State	artment of Health and Mental	2000 15001
			Registrer 1. Decedent's Name (First, Middle, Last)	2. Date of	Reg. No. U U 3 3. Time of Death
	Physici	ian	Sandra Ruth Lindt	Month	Day Year
	/Medi		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	14, 2006 10:15 PM
	Examir	ner	303 Overview Drive		Harford
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Abingdon If Under 1 Year If Under 24 Hrs. 8 Date of	
	Funeral Director		212-46-7988 1 M 2 MF 61 Yrs.	Months Days Hours Min (Month	f Birth 9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent	Februa	ry 4, 1945 Mosyland
	/land		10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
	Man-fish	to	Maryland Harford Abino	das	1 XYes 2 No
	the 28s	rec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	With Be or	by Funeral Director	303 Overview Drive	21009	USA
	ns 23	era			
	ter d	ä	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Specify Yes of Yes, Specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
36	irs at	by		I ☐ Yes 2 ☑ No Specify:	Specify: White
ŏ	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28a-f show I's Madical Examinar must be notified at	ed		lent's Usual Occupation	16b. Kind of Business/Industry
15	in 72	piet	(Specify only highest grade completed) (Give	kind of work done during most of working DO NOT use retired)	100. Kind of Business industry
21215-0036	filed with Hygiene. other than	Completed	Elementary/Secondary (U-12) College (1-4or 5+)	ecretary	Equipment Rental
	filed Hygie other ant, II	O	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mil	
an	should be tand Mental I a marked of umatic eva	To B	Donald Steeves	Nasa	Magsamen
7	and M la mar	-		g Address (Street and Number or Rural Route No	
Maryland	id 2 Ith av 27 ia 17 ia				
	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23e or 28a-f show or other traumatic event. If a Madical Examinat must be notified at			Overview Drive Abinge Date Date	20c. Location - City or Town. State
<u>o</u>	Pages nent of l int: If Its iry or o		1 Burial 2 Cremation 3 Removal from State	iatory or other place) Nau 15, 2001	111
Baltimore,	# 문 원 등		'4 Sonation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22	11445 Registry May 15, 2001 Name and Address of acility Aratomy Go 22 Connelley Drive Suite P	Hanover, MID
Ba	permi Depa Impo any ii		21. Signature to Pulletal Service Liberisee	Name and Address of acting Anatomy G	tts Kegistry
			22a Part 1 Enter the disease or complications that account the death. Do not set	22 Connelley Drive Suite P	Hanover, MD 21076
Į,			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	or the mode of dying, such as cardiac or respirato	ry arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition caution in death)	CANCER	3 YEARS
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
	Examine		Sequentially list conditions, b.		
	p is	Examiner	if any, leading to immediate cause. Enter Underlying cause. Enter Underlying cause ibuseas or injury		
	and tran	аш	that initiated events c.		
30,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		Due to (or as a consequence of):		
8760,	ate t hysic the b	Physician/Medical	d		
9	death certifica attending pt d for use as t	Mec	IF FEMALE:		
Вох	ith ce tend or us	an/	23b Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy	23d. Date of delivery
. E	e des	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)	Month Day Year
P.0	at the de d by the a stached	Phy	3 🗆 Ouknown		
Ś	res tha igned to be det	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23e. D	old tobacco use contribute to the cause of death?
ord	w require been si should t	ted		1	☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	law r as be 2 sh	Completed		24a. V	
Œ.	The ate has page	E		p 1 TY	erformed? death?
ita	i clan: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death (Check or	
>	d S	OB	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatient	Oth	desidence 6 Other (Specify)
	g Ph ter th neral	<u>n</u>	27. Manner of Death X Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)		be how injury occurred
jo	Attanding Fir death. ector: After by the funer	atio	Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No	
Division	or Attand after death Director:	Certification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 6 ☐ Could not be determined building, etc. (Specify)	et, factory, office 28f. Location	n (Street and Number or Rural Route Number,
ā	al or A s after al Direction by	Seri	building, etc. (Specify)	City of	Town, State)
	e Hospital or, 24 hours after a Funerel Dire letely lilled in t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	the Ho	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or invious) and manner stated.	estigation, in my opinion, death occurred at the tir	ne, date and place, and due to the cause(s)
	To the Hos within 24 ho To tha Fune completely I	≥ I	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1		> Dydung Pitysician	DS3590	MAY15, 2006
1			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) 6 24 2 BROADLIA	4
4			30. Name and aedress of person who completed cause of death (Item 23a) (Type, F Sup 14 Du Nova 6 Co. 2 M 6	BALTIMONE MI	21205
1	Sta	te	31. Date filed (Month, Day, Year) 8 2006 32. Segistrar's Signature	action to	
	Registr	ar	WAT I & ZUUD	T KA	

		•	For State Registrar		State of M	laryland .		artment of H rtificate of I			giene Reg. No.	006	15665		
100	ž.		1. Decedent's Name (First, Middle, La	st)					2. Date of De	eath Day	Year	3. Time of Death		
	Physicia		Audrey 2	A. LeCo	ompte					May 16,	2006	1041	6:40 P ^M		
	/Medic Examin		4a. Facility Name (If no	ot institution, giv	e street and number)		4b. City, Town, or	Location of Dea	ath	4c. Co	ounty of Death			
4.		Ø.	Franklin V	Woods Nu				Rossvi.				altimon			
* .	Funeral Director		5. Social Security Num 212–18–54		6ex I□M 2X F 8.	ge (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1920	9. Birth Cou Md.	place (State or Foreign intry)		
	p ,		Usual Residence of Do	ob. County		10c. City, T	own or Lo	cation					10d. Inside City Limits		
	ehow	7	Md.	BAltin	nore	l co. o.ly, .	Dund						1 ☐ Yes 2 X No		
	Ne M	ecto	10e. Street and Numb	101			Danc	10f. Zip Code			10g. Citizer	n of What Cou	intry?		
	with t	ក់	103 Cente		Ant	. 330			222		_	USA	,,		
	eath	erai	11. Marital Status	si riace	12. Was Deceden		13.	Was Decedent of H		Specify Yes or No		Race - Ameri			
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Extrinition; unit to rediffed at once.	by Funeral Director	1 Never Married		Armed Forces 1 Yes 2 If Yes, Give X Year or Dates:	? No	1	if Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	erto Rican, etc.)		Black, White, pecify: Whi			
Š	2 hou	ted	, 11	5. Decedent's E	ducation	1	6a. Dece	dent's Usual Occup	ation	nduna	16b. Kind	of Business/Ir	ndustry		
215	hin 7 n 'n Med	Completed	(Specify Elementary/Second	only highest gra lary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	()	OIKHIG					
2	gient gien er th	Con	12 vrs.				Cler	k			Hospit				
pu	d oth	Be	17. Father's Name (Fi							ame (First, Middle	, Maiden Su	<i>ma</i> me)			
yla	Ment Ment arke	ဂ္	Solomon						Joy He						
Maryland	2 sh and Is m	i	19a. Informant's Nam					ng Address (Street							
	and ealth m 27	}	Linda Cal		niece	20h Plac		5 Cedar (circie L	r. Caton		e Ma. Z			
Baltimore,	Pages 1 ment of H ant: if ite ury or ot		20a. Method of Dispose 1 ☐ Parial 2 ☐ 4 ☐ Donation 5	Cremation 3	Removal from State	cem	etery, crei dowri	dge Cem.	2	y 20 2006		cridge	OWIT, State		
Balt	Depart Import ony in		21. Signature of Fune	ones !	C. Co.	unel	les 9	2. Name and Address Sonnelly E 1110 Solle	uneral	t_Rd_21	222	Lk			
			23a. Part1. Enter the shock, or heart	disease or confailure. List only	plications that cause one cause on each	ed the death. I	Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between		
	Physician		mmediate Cause (Final sissasse or condition a. STROKE												
	/Medical		resulting in death) Due to (or as a consequence of):												
	Examiner		Sequentially list cond	litions.				LERUT		DISE	ASE				
	P #	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly	ediate ring	Due to (or a	s a consequer		BETE	5						
	icate be executed physicien and s the burial-transit	саш	cause. Enter Underly Cause (Disease or in) that initiated events resulting in death) La	st	C	s a consequer		BEIL							
68760,	be ex cien a	Ē	,		Due 10 (01 a	s a consequen	100 017.								
87	physic	dlcai		•	d										
Box (Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 2 3 9 ☐ Unknown	onths?		e of pregnanc 2 □ Fetal de at time of deat	ath 3[Ectopic pregnancy Other (specify)			230	d. Date of deliv Month	very Day Year		
P.0	that the od by detac		Part II. Other signific	ant conditions	contributing to death	but not resulting	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?		
ds,	uires tha signed Id be del	d by								1 🗆	Yes 2	No 3∏Pro	bably 4 Unknown		
Ö	w require been si should t	iete								24a. Was	an 2	24b. Were aut	opsy findings available		
Records,	he lav e has	Completed									psy ormed2	prior to co	ompletion of cause of		
a	in: T ificeta or, pa	e C	25. Was case referre	d to medical					26 Place of D	1 ☐ Yes eath (Check only	225 No	1 🗆 Yes	2, No		
of Vital	sicia s cert	To B	examiner?		Hospital:	tient 2□ER	VOutpatie	nt 3 DOA Oth		Home 5 Resi		Other (Speci	ifv)		
o	Phy er this		27. Manper of Death		28a. Date of In	jury 25	Bb. Time o			28d. Describe			,,		
Division	ath. T: Afte	atio	1 Natural 2 ☐ Accident	5 Pending investigation		ay rear	Injury	M 1 🗆	Yes 2 □No						
<u>×</u>	Atte	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could not I	286. Flace of I	njury - At home	, farm, st	reet, factory, office		28f. Location ((Street and N	lumber or Rui	ral Route Number,		
Ö	s afte s afte ai Dir	Cert	4 E Homedo		building,	sic. (opacity)					, 0.0.0,				
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	edicai Certification:			hysician: To the bes miner: On the basis and manner:	of examination									
	To the To the Comp	Me	29b. Signature and tit	tle of certifier	2 , ,	10		29c. Licens		8	_ [signed (Month,			
	~~		yen	to	ashed			וע	-00	9	211	110	6		
	8		JIM	PARS	completed cause of	death (Item 2:	3a) (Type,	Print) PANKL	N S	RUAPE	DR.	BALT	omore, M		
	Sta Registi		31. Date filed (Month)	, <i>Day</i> , Year) Y 1 8 20	no Hegis	irars signatur	Los								
10		- 4	17174	1 7 0 20	AND THE PERSON	10 50	3								

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lugh Jacob McWhinney	State of Maryland / Department of Health
1. For State	0 (5 (55)

		Registrar		Ce	ertifica	ate of	Death				eg. No.	_ 4	JUO		000
⊷ Physici Medical Exam		Decedent's Name (First, Midd Hugh Jacob		Date of Dea Month	Day	Year	3	Time of De							
ilodiodi Exam		4a. Facility Name (if not institution		,		41	o. City, Town, o	r Location		May 13, 2		c. County of	Death		5
		780 Swanton Road					Swanton					Garrett			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birth	nday)	If Under 1 Ye			8. Date of Bi	th(MM/			lace (State	
Director		579-40-0407	1XM 2_F		74	Yrs.	Months Day	ys Hours	Min.	May	12,	1932	Countr	Distri ^(y) Colu	.ct U umbia
any		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town	or Locatio	2								
*		Maryland Garro		100. 01.		anto								Od. Inside Ci	•
Maryland 28a-f show	ctol	10e. Street and Number					10f. Zip Code				0a. Citi	zen of What			
ith the Maryland 23a or 28a-f sho notified at once	Director	780 Swanton Ro	oad				21561				. J	USA			
with ms 23.	əral	11. Marital Status	12. Was Dec	cedent Ever in U	J.S.		Decedent of Hi	ispanic Orig			- 7	14. Race		Indian, Bla	ack,
or ite	Funeral		larried Armed F	2 No			s, specify Cuba		, Puerto Ri	can, etc.)	ĺ	White,	∍tc.		
s after ral",	by	3 Widowed 4 Div	orced If Yes, Give Yes or Dates:	· 50 - 52	Tio s		es 2 X No					Specify: W			
2 hours af "natnral Examin	eted	 Decedent's Education (Spe Elementary/Secondary (0-12) 					Usual Occupa t of working life				16b. k	Kind of Busin	1ess/Indu	istry	
0036 within 72 iene. er than '	omple	12	00.1090 (,	L	abor	er				Pa	aper I	.ndus	trv	
5-0(led wi Hygier other	O	17. Father's Name (First, Middle,	, Last)		1			18.Mother	's Name (F	Name (First, Middle, Maiden Surname)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Unk.							lnk.						
O 8 5 ≈ ±	은	19a. Informant's Name/Relations Judy Bakshi, Da	1 1 21 1		2.0		Address (Stre							o Code)	
		20a. Method of Disposition	augitei	20b.	Place of	Dispositi	se Glen (on (Name of ce	circle metery.		ax Stati		VA ZZ		vn State	
Baltimore, permit Pages I at Department of Her Important: If ite		1 Burial 2 X Cremation		om State	cremato	ry or othe	r place)		05.44	6 106			•		
ltin nit P artme ortan		4 Donation 5 Other State 21. Signature of Funeral Service	becify: Licensee	IMet	tro	Crema 122_Na	atory I	nc. s of Facility	05/1	16/06		1timo	re,	Maryl	and
Balt permit Depart Import injinry	Inollas Gregor / /one X/2 299 Frederick Road Balti										/lar	nd Inc	vlan	d 21	.228
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that c		Do not	enter the	mode of dying	, such as ca	ardiac or re	espiratory arre	est, sho	ck, or heart	А	Approximate	Interval
/Medical ≒xaminer	Immediate Cause (Final disease a. Intraoral Gunshot Wound										Between On Deat				
		or condition resulting in death)	Due to (or as a	consequence of	of):										
	Jer	Sequentially list conditions, if any, leading to immediate		consequence of	of):										
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	. 6.	consequence of	Sf\-								_		
ecuted and transit		events resulting in death) Last	d d	consequence o)i).								- 1		
e exec cian ar rial - t	an/Medical	UNPENDED	AMENDED			_	-						_		
68760, ertificate be exe ding physician a	/Me	IF FEMALE: 23b. Was decedent pregnant in th		outcome of preg	nancy					_	23d	. Date of de	livery	_	
certification	cian	past 12 months?	I I LIVE D	irth ant at time of de	2 eath 5		death 3	Ectopic	pregnancy	/		Month	Day	Ye	ear
O. Box 6 at the death cer I by the attendi	Physicia	1 Yes 2 No 9 Uni	known 9 Unkno		5	Othe	(Specify)								
P.O.	by PI	Part II. Other significant condit	ions contributing to	death but not r	esulting	in the und	lerlying cause of	given in Par	rt I.			ise contribut			
S, P.C uires that n signed b										1 Yes	2 🗸	No 3	Probably	4 Un!	known
ord aw req as bee	Completed									24a. Was a autops	sy			y findings a detion of ca	
Rec The Licate h	Som									perform 1 ✓ Yes 2		dear	th? Yes	2	No
tal cian:	Be (25. Was case referred to medica examiner?	(Hospital:					of Death (
of Vital Records, in Physician: The law requiring the true certificate has been sineral director, page 2 should the	0	1 Yes 2 No 27. Manner of Death	28a. Date	npatient 2		patient 3 me of Inju		Other 4	Nursing H	ome 5 1 d. Describe h		nce 6 🗸 ()ther: Sce	ene	
OD C	Certification: T	1 Natural 5 Pend	ing FOUND	Day Year)	FOUN	ND:		Yes 2 🗸	ISu	bject shot		ry occurred			
Division tal or Attendir is after death. al Director: A led in by the fu	ficat		May 13, d not be 28e. Place	2006 e of Injury - At h	0946 ome, farr					f. Location (S	treet an	id Number o	r Rural R	oute Numb	er City
Division pital or Attencours after death eral Director:	erti		and the state of t	Home						or Town, St O Swanto r	ate)				on, only
Hos 24 h Fnn etely		29a. Certifier 1 Certifying Pt	ysician: To the bes	t of my knowled	ge, deati	h occurred	d at the time, da	ate and plac	ce, and due	to the cause	(s) and	manner as	started		
To the within To the compl	Medical	one) 2 Medical Exam	and manner s	of examination a tated.	ind/or inv	estigation			urred at the	e time, date a					
	Σ	29b. Signature and title of certifie	000				29c. Licens					ate signed		Jay, Year)	
- T		Tolklin	- 10KK	10			O.C.I	IVI. □ .			May	14, 2006			
8	- 1	 Name and address of person Patricia Aronica-Pollal 		e of death (Item ant Medical I		ner 1	11 Penn St	reet. Bal	timore. I	MD 21201					
St	ate	31. Date filed (Month, Day, Year)	a a	gistrar's Signali		noch	7	.,							
Regist	rar	MAY T 8	ZUUD ZILO	CASIA AND	J. J.				4						

Constance Louise McWhinney

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State of I	Maryland /	Department	of Health	and Menta	al Hygien

nstance Louis		, oldio of Maryland , bopa.	ificate of Death	Reg No	2006 1566
Physicia edical Exami	an/	Decedent's Name (First, Middle, Last) Constance Louise McWhinney		2. Date of Death Month Day	3. Time of Death Year 0946 hrs
FUICAI EXAIIII	Hei	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea	May 13, 2006 th 4c. 0	County of Death
	Ц	780 Swanton Road	Swanton		errett
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	76 Yrs. Months Days Hours M	,	929 9. Birthplace (State or Foreign Country) Mary Land
		216-38-1857 1 M 2 NF Usual Residence of Decedent	/ O Yrs.	May 20, 19	729 Codition Planty Land
w any			own or Location		10d Inside City Limits
yland a-f sho	tor	Maryland Garrett 10e. Street and Number	Swanton Tof. Zip Code	I 10g. Citize	1 Yes 2 X No
he Mau 1 or 28 ified a	Director	780 Swanton Road	21561		USA
n with 1 ms 23s	Funeral	11. Marital Status 12. Was Decedent Ever in U.S		Specify Yes or No- 14	Race - American Indian, Black, White, etc.
er death , or ite	Fun	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		
urs afte itural"	d by	or Dates:	16a. Decedent's Usual Occupation (Give kind o	f work done 16b. Kin	pecify: White and of Business/Industry
6 n 72 ho an "na ical Ex	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use re		O II
-003 d within	Completed	12 17. Father's Name (First, Middle, Last)	Homemaker 18.Mother's Nar	ne (First, Middle, Maiden Su	Own Home
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be (Jesse Woods		hryn Powell	
	То	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number o 8635 Chase Glen Circle F		
e, MD and 2 sho Health and item 27 is			ace of Disposition (Name of cemetery, ematory or other place)		cation - City or Town, State
MOF Pages lent of int: If		1 Burial 2 X Cremation 3 Removal from State	ro Crematory Inc. 05	5/16/06 Bal	timore, Maryland
Baltimore, permit. Pages I an Department of Hea Important: If itei		21. Signature of Funeral Service Licensee	l Inc. Maryland 21228		
Physician		Thomas Gregor //www.2014. 23a. Part I. Enter the disease, or complications that caused the death. I	k, or heart Approximate Interval		
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a. Shotgun Wounds (2) of	Between Onset and Death		
CXAIIIIIIEI		or condition resulting in death) Due to (or as a consequence of)			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)			
760, icate be executed physician and the burial - transit		d			
60, ate be ex ohysician ne burial	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregna	ancy	23d	Date of delivery
6876 ertifica ding ph	-	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic preg		Ionth Day Year
of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certificate that sertificate has been signed by the attending tuneral director, page 2 should be detached for use as 1	ıysician	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
.O. F hat the ed by th	by Phy	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.		e contribute to the cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rate death. all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact				Yes 2 V	No 3 Probably 4 Unknown 24b. Were autopsy findings available
COFC faw re has be e 2 sho	Completed			autopsyperformed?	prior to completion of cause of death?
I Re n: The rtificate or, pag	CO e	25. Was case referred to medical	26.Place of Death (Chec	1 ✓ Yes 2 No k only one)	1 Yes 2 No
Vita hysicia this ce	To B	TV Tes 2 No -			ce 6 Other: Scene
n of ding Ph. h. After t		27. Manner of Death 1 Natural 5 Pending Pending 28a. Date of Injury FOUND: Day, Year)	28b. Time of Injury 28c. Injury at Work? FOUND: 1 Yes 2 V No	28d. Describe how injury Subject shot	occurred .
risio r Atten ter deat irector n by th	ficat	2 Accident Investigation May 13, 2006	0946 hrs		Number or Rural Route Number, City
Diversal or ours affilled in	Certification:	4 Homicide determined (Specify) Home		or Town, State) 780 Swanton Road	, Swanton, MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Uneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge one) Wedical Examiner: On the basis of examination an			
To t With Com	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
1		Fot Gronis - Kollele	O.C.M.E.	May 1	14, 2006
8		30. Name and address of person who completed cause of death (Item 2 Patricia Aronica-Pollak MD. Assistant Medical E	23a)	ore MD 21201	* *************************************
	tate	<u> </u>		510, IVID 21201	
Reais		TVLLT I () / [IIII] PRESENCE A AA			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Meth 17, FRANCES MILLER 2006 8:00 ам /Medical 4a. Facility Name (If not institution, give street and number)
1423 Race Street 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 5. Social Security Number 219-38-3517 8. Date of Birth (Month, Day, Year) June 13,1942 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 63 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Maryland N/A Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 1423 Race Street U.S.A. 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Meadows Air 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Ire Magneta College (†)4or 5+) Elementary/Secondary (0-12) Factory Worker Freshener 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonio Mosca Alberta Jackson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Miller (Daughter in Law) 1423 Race Street, Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cem-tery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 5-20-06 Baltimore, Maryland 21. Signature of Funefal Service Licenses Accuracy Polyniak Funeral Home P.A. 130 E. Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregrant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown 24a. Was an autopsy performe 24b. Were autopsy findin s milable prior to completion ause of death? s certificate has b 2 Z No 1 Yes 2 No 1 Tyes or Attending Physician: 25. Was case referred to examiner?
1
Yes 2 No director, Medical Certification: To Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this After thi 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director; 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date sized (Monh, Day, Year) of death (Item 23a) (Type, Frint) State Registrar

	1	For State	State of M	•	epartment of F		ntal Hygie	2000	1566	
	1	Registrar Decedent's Name (First, Middle, La	uet)				Date of Death	140.	3. Time of Death	
Physician	ľ							Day Year	12:550	
/Medical	L	MARTHA LE		CALIP	4h Cihi Taum o	Location of Death	May	4c. County of Dea		
Examiner	4	a. Facility Name (If not institution, give	e street and number) : = ~ 1	Go Il	Location of Death	9	4c. County of Dea	uı	
無人 (大木)		Maryland Gen		pital	hday) If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	0.00	thplace (State or Foreig	
- Funeral	5	9.	Sex 7. A 1 □ M 2 √2 F	ge (In yrs. last birt	Months Days	Hours Min-	(Month, Day, Ye	ear) Co	ountry)	
Director	-	217-24-3340	Α	81			5 18	1924	VA	
pua *	-	Oa. State 10b. County		10c. City, Town	or Location				10d. Inside City Limi	
aryi e de or		MD N/A		BALI	IMORE				1 ∑ Yes 2□N	
or 28e-fello or 28	-	0e. Street and Number			10f. Zip Code		10a.	Citizen of What Co	ountry?	
with the sor	'	2503 VIOLET A	VE. "ΔΡΤ]	OLOSOUTE		215		U	-	
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health end Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23s or 28s-f show other treumatic event, its Madical Examinat must be notified at To Be Completed by Funeral Director	_		12. Was Deceden		13. Was Decedent of H	215	fy Ves or No-	14. Race - Ame		
tem tem	1	1. Marital Status	Armed Forces	?	if Yes, specify Cuba	an, Mexican, Puerto Ri	can, etc.)	Black, White		
y Fl		1 Never Married 2 Married	1 ☐ Yes 2☐ If Yes, Give	No	1 ☐ Yes 2 🙀 No	Specify:		Specify:	or a care	
urat'		3 ☐Widowed 4 ☐ Divorced	Year or Dates:		Decedent's Usual Occup	ntin n	10	b. Kind of Business	BLACK	
nat	1	15. Decedent's E (Specify only highest gr	ade completed)	10a.	(Give kind of work done life. DO NOT use retired	during most of working		J. KING OF BOSINGSS	rindustry	
within then then within then within the Man		Elementary/Secondary (0-12)	College (1-4or	5+)		<i>.,</i>		TIOMI	3	
Hygie Hygie ant. to e Co		12th	N/A_		HOMEMAKER	18. Mother's Name (First Middle Mai	HOMI	<u> </u>	
d otl		7. Father's Name (First, Middle, Las					_			
should be nd Mental n marked o umatic eve		FOUNTAIN	PARRISH			MARTH		TYLER	71.0 ()	
end end bue		19a. Informant's Name/Relationship			Mailing Address (Street					
Health em 27 other tr		PAMELA FRANKS-DA	UGHTER		0410 FRANKFO Disposition (Name of	Da Da		c. Location - City or		
Pages Department of Pages Department of Important: if Important: if Important: or or or or or or or or or or or or or		23a. Part1. Enter the disease, or a shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Meta	Stolie	not enter the mode of dyir	ORTH AVENU	E BALTIM	AL HOME-I	21202 Approximate Interval Between Onset and Death	
physician and the burial-transit the burial-transit dical Examiner	eulcai Evalilliei		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Du	s a consequence s a consequence s a consequence s a consequence	Dysoil Sion	tuna			
ne death certiff the attending i hed for use as	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) □	/		23d. Date of de Month	Hivery Day Year	
requires that the search of the signed by nould be detacted by Physical By Physical by Phy		Part II. Dther significant conditions	contributing to death	but not resulting in	n the underlying cause giv	ven in Part I.			o the cause of death?	
n: The law require reate has been sign. r. pege 2 should to							24a. Was an autopsy performed	d? death?	utopsy findings availa completion of cause	
e tifica	>	25. Was case referred to medical				26. Place of Death				
Physicien: this certific ral director.	.	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	tient 2 ER/Ou	itpatient 3 DOA Oth	ner: 4 Nursing Hom	e 5 ☐ Residenc	e 6 □Other (Spe	ecify)	
g the Co		27. Manner of Death 1 □ Matural 5 □ Pending 2 □ Accident investigate	on	njury 28b. 1	Fime of njury 28c. Injury Wo	ry at 28 rk? Yes 2 No	d. Describe how	injury occurred		
or Atterde Directo in by the		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	208. Place of I	injury - At home, fa etc. <i>(Specify)</i>	rm, street, factory, office	28	Bf. Location (Stree City or Town, S		Rural Route Number,	
t hours		29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	Physician: To the bes aminer: On the basis and manner:	of examination an	a, death occurred at the trid/or investigation, in my	me, date and place, ar opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)	
within 2. To the figure complete		29b. Signature and title of certifier	0 00	1	29c. Licen:	se number	29d	. Date signed (Mon	th, Day, Year)	

State Registrar

MAY 1 8 2008

in (Item 23a) (Type, Print)

Clo Maryland C-eneral
s Signature

			For	. 10000			and / Dep	artment	t of H	ealth a		-		2000	مر سا و	7.0
			1 - For State Registrar				Ce	rtificate	e of L	Death			Reg. No.	2006	155	10
	Physici	an	1. Decedent's Name (Fi									2. Date of Do	eath 13	Year	3. Time of	
	/Medic		4a. Facility Name (If not					4b. City. 7	Town, or	Location o	of Death	May		2006 County of Death	10:00	p _M
	Examin	er	717 Maiden	-			305	Caton		_	.,			ltimore		
	Funeral		5. Social Security Numb	per 6. Se	эх	7. Age (In y	rs. last birthday,			If Under :	24 Hrs. Min.	8. Date of Bi (Month, D	rth av. Year)	9. Birth	place (State or intry)	r Foreign
	Director		362-18-537	1	©M 2□F	89	Yrs.		,-			April	17,1	917 Ohio		
	land ow			b. County		10c.	City, Town or L	ocation							10d. Inside Cit	ty Limits
	Many a-f sh	tor	MD Ba	altimor	e	Cat	onsvill	.e							1 🗆 Yes	2 _√ No
	or 284	Jirec	10e. Street and Number					10f. Zip					10g. Citi	zen of What Cou	intry?	
	s 23a	by Funeral Director	717 Maiden	Choice				2122					U.S.			
	ter de	Fune	 Marital Status Never Married 	2CXMarried	Armed Fo	edent Ever in orces? 2 □ No	0.5. 13.	If Yes, speci	ent of His ify Cubai	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.)	0-	 Race - Amer Black, White 		
98	ours at	by	3 Widowed 4		If Yes, Gi Year or D	ve		1 ☐ Yes 2	XIXNO	Specify:			,	Specify.Whit	e	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "naturel", or Itams 23a or 28s-1 show ent, the Medical Ezantiner must be ricitified at	Be Completed	15. (Specify o	Decedent's Ed	ucation de completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	l Occupa k done d	ition Juring most	t of workii	ng	16b. Ki	nd of Business/li	ndustry	
121	within ane. then '	ldmi	Elementary/Secondar	ry (0-12)	College (DO NOTus Sticia)			Fode	eral Gov		_
д 5	filed Hygie other ent,	e Co	17. Father's Name (Firs	t, Middle, Last)	5+		beaci	. SCICIO		18. Mothe	r's Name	(First, Middle			ernmen	Ε
<u>lan</u>	Aental rked c	To B	Joseph Marz	zetti						Pia D	iPie	ro				
Maryland	2 sho and h Is ma		19a. Informant's Name/	Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	Route Numb	er, City o	r Town, State, Zi	Code) 2	1228
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or Itams 23a or 28a-1 show any injury or other treumatic event, the Madical Examinat must be notified at ODCe.		Josephine F 20a. Method of Disposit		etti/Wi		717 M	aiden	Cho	ice L	ane	Apt ST		Catonsv		D
Baltimore,	ages nt of h t: If ite		1 ☑Burial 2 ☐ Cr	remation 3 🗆			Place of Dispo cemetery, cre udon Pa							cation - City or T		
Ē	nit. Partme artme ortan injury		`4 ☐ Donation 5 ☐ 21. Sign to e of Funer			ДО	2	2. Name and	d Addres:	s of Facility	У			imore,	MD	
ñ	Depar Impo		. lean	PA	uhical)	A	mbrose	e Fur	neral	Hom	e, Inc	• *h+.	ıs MD 21	227	
			23a. Part1. Enter the di shock, or heart fai	isease, or comp	lications that one cause on e	ceused the de	eath. Do not en	ter the mode	of dying	, such as	cardiac o	r respiratory a	rrest,	r o Min C i	Approximate Interval Betw	veen
В	Priysician		Immediate Cause (Fina disease or condition	al	a	5+	roke	, er	nbo	11'c					Onset and D	eath
П	/Medical Examiner		resulting in death)		Due to	(or as a cons	equence of):	, -								
	300	ē	Sequentially list condition if any, leading to immediate. Enter Underlying	ons, diate	b. Due to	(or as a cons	equence of):									
/	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injurathat initiated events	g s	С.											
,092	ate be executed hysician and the burial-transit	Exa	resulting in death) Last			(or as a cons	equence of):									
ന	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical			d								-			
Box 6	leath certific attending p	√Me	IF FEMALE: 23b. Was decedent pre	agnant .	23c. If yes, ou								,	3d. Date of deliv	en/	
	death e atte	Physician/M	in the past 12 mon	nths?	4☐Pregr	oirth 2 ☐ Fe nant at time of		Ectopic pre Other (spe					- [[Month	,	ear
o.	res that the de signed by the a be detached f	Phys	9 Unknown		9∐ Unkn											
S,	res th	by	Part II. Other significan	it conditions co	entributing to d	eath but not r	esulting in the u	nderlying car	use give	n in Part I.				se contribute to t		
Records,	w require been si should I	eted										10		•	oably 4 🗆 Ur	
Re	he fav e has	Completed										24a. Was auto perfo	psy ormed?	death?	mpletion of ca	vailable use of
ta	Physicien: The la r this certificate has ral director, page 2	ø	25. Was case referred t	to medical				<u></u>		26 Place	of Death	1 ☐ Yes (Check only o	2X No	1 🗆 Yes	2 No	
>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 (No		Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA	Other	_		-		Other (Special	y)	
Division of Vital	Attending Physicien: r death. sctor: After this certifics by the funeral director, i		27. Manner of Death 1 Natural 5	Pending		of Injury th, Day Year)	28b. Time o Injury		c. Injury Work			8d. Describe	how injury	occurred		
S	Attend er death rector: / by the f	lcat	2 Accident 3 Suicide 6	investigation Could not be	-	of Injury - At	home, farm, str	M factory		es 2□N		8f Location /	Stroot and	l Number or Rura	I Bauta Alumb	
<u>≥</u>	in Sire	Certification:	4 Homicide	determined	buildi	ng, etc. (Spe	cify)	cer, raciory,	Office			City or To	wn, State)	I IVUINDEI OI MUIS	u noute ivanib	e1,
	ospita hours unera ly fille		29a. Certifier (Check only 2	Certifying Phy	/sician: To the	best of my k	nowledge, deat	n occurred a	t the time	e, date and	place, a	nd due to the	cause(s)	and manner as s place, and due to	tated.	
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	Medical	Une)		and man	ner stated.	mation and/or in				n occurre	d at the time,				
	To To Con	-	29b. Signature and title	or certifier	~ O			29c.	License	number)		29d. Date	signed (Month,		
	70)	30. Name and address	of person who		se of death (Its	em 23a) (Tvne	Print)	7 /	177	/		Alex	, , , , ,	36 (
	3		Andrew	(9 7 G	4		Maidi		hoi	10	lan	e (a ho	nsv.16	Mary	10
	Sta	_	31. Date filed (Month, D	Pay, Year)	76 32 F	egistrar's Sig	nature A	wie							J-	
	Registr	ar	111/11	1 0 20	JUE!	wer s	a popular									

			For State Registrar	State of	Marylan			nt of He te of D		ind M	_	giene	2 U U	6	15671
	nysicia Medic		1. Decedent's Name (First, Middle, Nina J. Michael	Last)							2. Date of De Month 5-14-	ath Da		ear	3. Time of Death 9:30 P M
2000000	xamin		4a. Facility Name (If not institution,	give street and numb	per)		4b. City	Town, or	Location o	f Death			. County of [Death	7.30 1
			11 North Carolin					aden					nne Ai	rund	e1
	neral ector		5. Social Security Number 225-46-2695 Usual Residence of Decedent	1. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs.	last birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 6-11-	ıy, Year)	9.	Birthpla Country VA	ce (State or Foreign y)
fand	=	1	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							100	d. Inside City Limits
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th the	not	lrec	10e. Street and Number	0		<u>., </u>	10f. Zi	o Code				10g. Cit	izen of Wha	t Country	y?
ath wi	ust b	ai	7021 Community	Center Ro	ad		22	821				U	.S.A.		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-1 show	aminer m	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ★ Marrie	If Yes, Give	es? ⋤No		Was Dece If Yes, spe 1 ☐ Yes	cify Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.))-	14. Race - / Black, V Specify:	White, et	
	al Ex	ed b	3 Widowed 4 Divorced	Year or Date	95:	16a. Dece			tion			105.46			
Baltimore, Maryland 21215-0036 sernit, Pages 1 and 2 should be filed within 72 hours alt Department of Heelth and Mental Hygiene. moordant: if item 27 is marked other than "natural", or	Medic	Completed	(Specify only highest Elementary/Secondary (0·12)		or 5+)	(Give	kind of wo	ork done di ise retired)	urina most	of working	ng	16b. K	ind of Busin	ess/Indu	stry
21 ad will	e i	Con	11			Home	emake						Own I	lome	
Dand Ibe iii	M V B V	Be	17. Father's Name (First, Middle, La Lenford Wilford	ist)							(First, Middle	, Maiden	Surname)		
hould Mer	matic	스	19a. Informant's Name/Relationshi	(Type Print)		10h Mailir	ac Address	C (Strant a	_	ie S	harp Route Numbe	or City	- T C4-	4- 7-0	
Ma Dd 2 s The an	rtrau		Mrs. Karen Foba		hter						.; Pasa				
S 1 av	othe	ŀ	20a. Method of Disposition		20b. P	Place of Dispo	sition (Na	me of			ate		cation · City		
Page Page nent c	ıry or		1 ☐ Burial 2 ②Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ate	esapeal	•		1	5-17	-2006		Steven	svi]	lle, MD
Balt permit Departr	any inj		21. Signature of Funeral Service Li	censee	Mo						gleton en Burr	Fune	eral H	lome,	
"**			23a. Part1. Enter the disease, or co shock, or heart failure. List of	omplications that cau	sed the death									A	Approximate
Physi			Immediate Cause (Final disease or condition		mar	u de	rito	nea	1	care	imor			0	Onset and Death
/Med Exam	-40		resulting in death)		as a conseq										(1,25)
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Je lie ve	insit	mine	Cause (Disease or injury	550 10 (6.	as a somsoq.	301100 017.									
O, exec	burial-transit	Exa	that initiated events resulting in death) Last	Due to (or	as a conseq	uence of):									
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x 66 ertifica	e as t	Med	IF FEMALE:					· .							
Box 6 eath certifii	detached for use	ian/	23b. Was decedent pregnant in the past 12 months?		h 2 Feta	Ideath 3□	Ectopic p						23d. Date of Month	,	ay Year
O # #	ched	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow	nt at time of do n	eath 5	Other (s)	овсту)							-,
Division of Vital Records, P.O. Box 6. I or Attending Physician: The law requires that the death certific after this certificate has been signed by the ettending p.	be deta	by Physician/Me	Part II. Other significant condition	s contributing to dea	th but not resi	ulting in the u	nderlying (ause giver	n in Part I.		23e. Did t	obacco u	ise contribut	te to the	cause of death?
ords aquire en sig	70										10	res 2	Ø N₀ 3□] Probab	ily 4 ∐Unknown
Record e law requents has been	2 sho	Completed									24a. Was		24b. Were	autop sy	y findings available
E et e	page	Con										rmed? 2 X No	deat	h?	itetion of cause of
Vita ician: serific	ector,	Be	25. Was case referred to medicat examiner?	Hanning						of Death	(Check only o	ne)			Daughter's
Phys.	raldır	2	1 Yes 2 No	Hospital: 1 Inp		ER/Outpatien 28b. Time of		Other 28c. Injury	4 🗆 1901		ne 5 Resid			Specify)	Residence
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Visio Attendi r death.	by the	ifica	3 Suicide 6 Could no determin	t be 28e. Ptace of	Injury - At ho	ome, farm, str	eet, factor				8f. Location (S	Street an	d Number o	r Rural R	Route Number,
Div	ni bel	Certification:			, etc. (Specif)						City or Tov				
DIV To the Hospitel or within 24 hours afte To the Funeral Dir	completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physicien: To the b seminer: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred vestigation	at the time i, in my opi	e, date and nion, deat	d place, a h occurre	nd due to the dat the time,	cause(s) date and	and manne place, and	r as state due to th	ed. e cause(s)
To the within 2	com	Σ	29b. Signature and title of certifier		440		29	c. License	number			29d. Dat	e signed (M	onth, Da	y, Year)
)				ren 1	W)			NSZ	850		/	Mary	15,20	06	>
2			30. Name and address of person with Jeanine Wein	er MD.	of death (Item 900	B(Sto	Print)	Roa	d,r	mno	apolis	, M	0	214	0/
Re	Sta egistr		31. Date filed (Month, Day, Year) MAY 1 8	2006	istrar's Signa	tyre	ack		1						

					State of Ma								0
		4	For State		State of Ma		ertificat			a Monta	Reg. I	- Z 11 11 h	15672
			Registrar 1. Decedent's Name (F	irst, Middle, Last)							e of Death		3. Time of Death
	Physicia		Donot	4	ANE	Ne	evlA	NC	-	MA		Day 200	100 CAM
	/Medic Examin		ta. Facility Name (If no	t institution, give st		01	4b. City,	Town, or L	ocation of C	Death	1	4c. County of Dea	th
			BAlto.	WASh.	med	Ctr	66	en	130	LYNI	e	H	H
	Funeral		5. Social Security Num 369-34-600	and a	7. Age	(In yrs. last birthda 70 Yrs.	Months		Hours I	Min. 8. Dat	e of Birth Inth, Day, Ye. 27-35	ar) 9. Bii	thplace (State or Foreign
	Director	-	Usuat Residence of De							0 2			
	yland 10W		10a. State 1	Ob. County		10c. City, Town or							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	a-f a	ctor	MD	Anne Arun	del	Glen B					.,		
	72 hours after death with the Maryland **nature1*, or Itema 23e or 28e-f ehow dical Evant er must be notitled at	Completed by Funeral Director	10e. Street and Number		.		10f. Zip	Code 061			_	Citizen of Whal C	ountry?
	ath w	rai	7904 Gentl		Court Ap 2. Was Decedent E	ot H			nanic Origin	n? (Specify Ye		14. Race - Am	erican Indian,
<u>}</u>	ter de	une	 Marital Status Never Married 		Armed Forces?	0				n? (Specify Ye Puerto Rican,	etc.)	Black, Whi	te, etc.
许贸	urs af	by F	3 ☐ Widowed 4		tf Yes, Give Year or Dates:	-	1 ☐ Yes	2E No	Specify:			Specify: Wh	ite
0 0	72 hou	ted	1! (Specify	5. Decedent's Educ only highest grade	ation completed)	16a. De	cedent's Usu we kind of wo . DO NOT u	al Occupat	tion uring most o	f working	16b	. Kind of Business	/Industry
27.5	within 7 ene. then "r	npie	Elementary/Second		College (1-4or 5-	+) Med	ισονοτυ ical Τ	se retired) ransc	ripti	onist	М	edical	
$\supseteq \overline{2}$	led w tygier her th	Co	17. Father's Name (Fig.								Middle, Maid	den Sumame)	
anc	Mental F Mental F arked of atic ever	To Be	Oscar He							Davis			
and Marylan	E E E	۲	19a. Informant's Nam		oe, Print)	19b. Ma	iling Address	s (Street ar	nd Number	or Rural Route	Number, Ci	ity or Town, State,	Zip Code)
	2 6 5 5		Mr. Thoma			790	4 Gent	le Br	ceeze	Court			nie, MD 21061
e, C	of Health of Health if item 27 or other tr		20a. Method of Dispos		Chata	20b. Place of Dis	position (Na	me of other place	9)	Date		. Location - City o	
e tu	Page: nent o int: If iry or			Cremation 3 □Re □ Other (Specify)	emoval from State	Sunset H	ills M	lem. F	Park 5			11evue,	
New	permit. Pag Depertment Important: I any injury o		21. Signature of Fune	ral Service License		1459				Single Glen		neral Ho	me, r.A. 1061
			23a. Part1. Enter the	disease, or complic	cations that caused	the death. Do not							Approximate tnterval Between
	Physician		shock, or heart tmmediate Cause (Fi	alture. List only on	e cause on each lin	riosc			1 (CArt	- 7	15C 434	Onset and Death
	/Medical		disease or condition resulting in death)	C a	Due to (or as	a consequence of):		110					
	Examiner		Supportails list over	Micros b	. _								
. 0	p #	iner	if any, leading to imm cause. Enter Underly Cause (Disease or in	ediate ring	Due to (or as	a consequence of):							
PI	be executed icien and burial-transll	Examiner	that initiated events resulting in death) La	- C	Due to (or as	a consequence of):							
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687	certificate nding phys use es the	edic				· · · · · · · · · · · · · · · · · · ·							
Вох	nding use e	Physician/Medi	IF FEMALE: 23b. Was decedent p	regnant 2	3c. If yes, outcome		3 □Ectopic p	regnancy				23d. Date of d	
ĕ.	death e atte	icia	in the past 12 m 1 □ Yes 2 🕱	onths?	4 □ Pregnant at		5 ☐ Other (s					Month	Day Year
P.O.	at the by th	hys	9 Unknown						- '- B1	20	2a Did tabaa	no uon contributo	to the cause of death?
S,	law requires thet the death certificate es been signed by the attending phy 2 should be detached for use es the	Ď	Part tl. Other signific	ant conditions cor	tributing to death be	ut not resulting in th	e underlying	cause give	en in Part I.	2.			Probably 4 Dunknown
ord	requir een s nould	Completed								_			autopsy tindings available
ခွ	e iaw hes b	hgm								- 2	4a. Was an autopsy performe	d? prior to	completion of cause of
a E	n: The licate he r. page		75 Was seen of an art and a seen of	d to modical					26 Blace	of Death (Che		No 1 ⊔Ye	s 2 No
₹.	Physicien: The lav r this certificate hes ral director, page 2	o Be	25. Was case referre examiner? 1 ☑ Yes 2 ☐ N	1	lospital: 1 ☐ Inpatie	ent 2 PA/Outpa	tient 3 🗆 🗅	Othe Othe	00			oe 6 ∐Other (Sp	eecify)
o o	g Phy er this eral d	n: To	27. Manner of Death		28a. Date of tnju (Month, Da	-	e of	28c. Injury Work	/ al	28d. D	escribe how	injury occurred	
<u>io</u>	Attending r death.	atlo	1 ANatural 2 Accident	5 Pending investigation	(1001101, 54	y / 32 ./	м		Yes 2 □ N	0			
Division of Vital Records,	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm c. (Specify)	, street, tacto	ory, office			ocation (Streetity or Town, S		Rural Route Number,
۵	Hospital of the Hours of Funerel Distriction in the Hours of Funerel Distriction in the House in	Ce	29a. Certifier	☐ Certifying Phy	sician: To the best	of my knowledge, of	eath occurre	d at the tim	ne, date and	place, and du	ue to the caus	se(s) and manner	as stated.
	To the Hospital or Attending P within 24 hours effer death. To the Funerel Director: After completely filled in by the funers	Medicai	(Check only 2 one)	Medical Exami	ner: On the basis o and manner sta	f examination and/o	rinvestigatio	on, in my op	pinion, death	occurred at t	he time, date	and place, and d	ue to the cause(s)
	To t To t	Σ	29b. Signature and t	itle of certifier	D Da	Der Der	1 2	9c. License	e number O LC	954	290	i, Date signed Mo	nin, Day, Year)
	1		30. Name and addre	ss of person you o	omple ed use of d	leath (Item 23a) (Ty	pe, Print)	1 1 =	- 7	2	/	5 15	
	7		WilliA	m Pi-	JONE	SIMD		945		Jme	VICA	+ 210	935
	St Regis	ate	31. Date filed (Month		Registr	rar's Signature	south)						
	negis	a cal	INC	0 5000	- Color	- 30 19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Year 1115 8:30 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death 3rd Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 45 M 20F 2 Director -10-1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23e Completed by Funeral 12. Was Decedent Eve Amed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 25 Yes, Give 'ear or Dates: 25 No Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 Tes 2 0 Specify: 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) COLK 17. Father's Name (First, Middle, Last) Be a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Jute Number, City or Department of Health a Important: if item 27 is any injury or other training. 21122 MD 20a. Method of Disposition 20c. Local on - City or Town, State Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licensee to ices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tear estive ears /Medical Due to (of as a consequence of): Examiner la O Vhe L Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physicien and for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ certificete has been si rector, page 2 should 2 🗆 No 3 Probably Be Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 20 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) attendina cardiologist

Registrar

State

JOUCE Zer 31. Date filed (Month, Day, Year)

MAY

8 2006

person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

		•	For State Registrar	State of	f Marylar				ealth ar Death	nd Me		giene	0.6	15674
	Ph. 133		1. Decedent's Name (First, Middle,	Last)						2	Date of Dea Month	ith Day	Year	3. Time of Death
10	Physici /Medic		Rose			Pa	jak				May	13,	2006	9:30P.M ^M
	Examin	er	4a. Facility Name (If not institution, Continuum Care	•			4b. City		Location of Sville				ty of Death Howard	
1,04	्वर				7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under 24		. Date of Birth			
	Funeral Director		220-03-3889 Usual Residence of Decedent	1 □ M 2 🔀 F	84	Yrs.	Months	Days	Hours	Min.	June 2	6,1921	Mar	ace (State or Foreign try) yland
	/land		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation						1	Od. Inside City Limits
	a-fst	ctor	Maryland Carr	ro11		Westmi	nstei	-						1 ☐ Yes 2 🗷 No
	or 28	Dire	10e. Street and Number				10f. Zi	Code				10g. Citizen of		try?
	ath w	rai	1567 Bloom Road	10.111		10			157	2 (2			.S.A.	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: If Item 27 is marked other than "natural; or Iteme 23e or 28e-f show any njury or other treumatic event, the Medical Examinar must be multiled at ances.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Fo	2 🔀 No 'e		was Dece If Yes, spe 1 Yes		Specify:	n ? (Speci Puerto Ri	fy Yes or No- can, etc.)	Speci	ice - Americ ack, White, o ify:	
ŏ	2 hou	ted	15. Decedent's			16a. Dece	dent's Usu	al Occupa	ation furing most o	of worders		16b. Kind of E	Business/Inc	
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7	led w lygier lygier her th	Cor	11	N/A			НС	mema		a Nama /	Fire Middle		vn Hom	ie
Maryland 21215-0036	should be filed vand Mental Hygie s marked other umatic event, In	To Be	17. Father's Name (First, Middle, La Stefan	451)	Lonc	zynski			Ju1		rirst, Middie,	Maiden Suma	Gasio	roski
Nar	2 short and is m		19a. Informant's Name/Relationshi Milton J. Pajak		22)		-					r, City or Towr		
e)	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any njury or other tre		20a. Method of Disposition	., Jr. (30	10.00					Dat		aryland		
Baltimore,	nt of h		1 ☑ Burial 2 ☐ Cremation		State	Place of Dispo cemetery, crer								
ᄩ	artme		4 □ Donation 5 □ Other (Special Service Li	-	GI	en Have	en Me 2. Name a	m. P.	K. 5	/18/	06	Glen Bu	ırnie,	Maryland
Ba	Department of the state of the) MI	111.	2		McCu] 237 E	ly-P	olynia Patans	ik Fu	neral Ba	Home, E Itimore	A. Mar	yland 21225
8760, 6	Physician physician and physician and physician and the purial-transit	dical Examiner	23a. Part1. Fafer the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a.y. cause (Disease or injury that initiated events resulting in death) Last	a	ach line.	Cincer quence of): had a quence of):	_	30 31 Gywig	g, 338/1 43 33		oophatory an		Cole 9	Approximate Interval Between Onset and Death
P.O. Box 6	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Solo 9 □ Unknown		inth 2 ☐ Feta ant at time of o	aldeath 3 [Ectopic p						ate of delive onth	ry Day Year
	res that igned by be deta	by Pt	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use cor	ntribute Io th	e cause of death?
rds	w require been sig should b										1 🗆 Y	es 2 30 0	3 🗍 Proba	ably 4 Unknown
l Records,	G 55 C1	Completed									24a. Was a autops perform	n 24b. sy med? 2 X Oo	Were autor prior to con death? 1 \(\sum \) Yes	psy findings available appletion of cause of
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of	Phys this ral dir	<u>1</u>	1 Yes 2 No 27. Manner of Death	1 1 1		ER/Outpatier 28b. Time of			4 A-Nursi			ence 6 Ot)
on	ding h. After funer	tion	1 Natural 5 ☐ Pending	1	of Injury th, Day Year)	Injury	м	28c. Injury Work 1 □ 1	res 2 ☐ No		u. Describe III	ow injury occu	ned	
Division	Il or Attending after death. Director: After d in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - At h	lome, farm, str					f. Location (Si City or Town		ber or Rural	Route Number,
Δ	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminar: On the ba	best of my knows	owledge, deatl	h occurred	at the tim	e, date and	place, an	d due to the c	ause(s) and m	anner as sta	ated.
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	With To To To To To To To To To To To To To	2	29b. Signature and title of dertifier	. /			29	c. License	number	•	2	9d. Date signe	ed (Month, L	Jay, Year)
,			with	46	M	00	D : - 1	100	5812	57		> 115	106	
	10		30. Name and address of person w	To Completed caus	e of death (Ite	m 23a) (Type,	307	41	estan 1	het-	- M.	0 71	157	
	Sta	ite	31. Date filed (Month, Day, Year)	006	mistrar's Sign	ature	The state of the s		- / 1 - 10	1116	, , , , ,	- (1	J /	
-	Registr	ar												

					State of Ma					•	-	jibie.					
				1 = For State Registrar	oldio or mo	*	Certificate			, ,	leg. No.2	106	15676				
		Dhysia	0.0	1. Decedent's Name (First, Middle,	Last)		0		1 2	2. Date of Dea Month		Year	3. Time of Death				
	197	Physici /Medi		WILLIAM	J.		Row				13.2	006	19=20 M				
		Examir	ner	4a. Facility Name (If not institution, g		_		own, or Location				ty of Death					
		Funeral		UPPER CHESARE 5. Social Security Number 6	Sex 7. Age	(In yrs. last birth	day) If Under			B. Date of Birth		9 Birtho	lace (State or Foreign				
	ь	Director		228-30-5069	1 StM 2 □ F 7 5	5 Y	rs. Months	Days Hours	Min. N	B. Date of Birth Month, Pay IOV • 4 •	1930	PA	ntrý)				
		and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits				
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		th the or 28s	lrec	10e. Street and Number			10f. Zip (1	l 0g. Citizen of		ntry?				
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumatic event, Ira Medical Exaction must be inclined at ance.	Funeral Director	13008 Fork Road				210				S.A.					
		ter de item	une	11. Marital Status 1 □ Never Married 2 Amarried	12. Was Decedent E Armed Forces? 1 1 2 Yes 2 □ N		13. Was Decede If Yes, speci	ent of Hispanic O fy Cuban, Mexica	rigin? (Speci an, Puerto Ri	ify Yes or No- ican, etc.)	14. Ra	ice - Americ ack, White,					
0	036	urs af	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify	/ :		Spec	ify: wh	nite				
2	5-0	72 ho 'natur	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. [Decedent's Usual Give kind of work	Occupation done during mo	st of working	7	16b. Kind of I	Business/Ind	dustry				
6	121	within ane. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NOT use	retired)									
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	/lan	uld be Mental irked itic ev	To B	Jay Rowan				Flo	ssie L	ee							
	Maryland 21215-0036	2 sho and ! is ma	ľ	19a. Informant's Name/Relationship		19b. l	Mailing Address (Street and Numb	ber or Rural I	Route Number	, City or Town	, State, Zip	Code)				
q		1 and Health In 27 Sm 27		Martha H. Rowan	/wife		3008 For		Baldw								
5113/06	Baltimore,	ages nt of h t: # ite		1 ☐ Burial 2 🖾 Cremation 3		cemetery	crematory or oth	er place)			20c. Location						
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To	ä	Departiment Department		+ flille			Schimu	nek Fund	eral H	ome of	Bel A	ir, In	nc.				
4				23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each line	the death. Do no	ot enter the mode	of dying, such a	s cardiac or i	respiratory arri	est,	10 • - 2 1	Approximate Interval Between				
		Physician		Scrimmer runeral nome of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 Approximate shock, or hear failure. List only one cause on each line. Sease or condition sulting in death) Due to (or as a consequence of):													
	-5"	/Medical Examiner		Tosuming at dozum	Due to (or as a	consequence of):										
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MOCCOCLO	Box (eath certificate be executed attending physicien and I for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		- 0-				23d. Da	ate of delive	rv				
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3	ital	stan: artifice ctor. p	Be C	25. Was case referred to medical examiner?				26. Plac	e of Death (1 □ Yes 2 Check on I on	Section 198	1 🗆 Yes	21,000				
\equiv	of V	Physician: this certifice ral director, i	ပ္	1 Yes 2 No	Hospital: 1 Inpatien		atient 3 DOA		ursing Home	5 🗆 Reside	ince 6 □Oti	ner (Specify)				
2	nc On C	ding Phys 7. After this funeral di	ilon:	27. Manner of Death 1 ≪Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tir Year) Inj	ne of 28	Work?		d. Describe ho	w injury occu	rred					
C	Division	Attending r death. ector: After by the fune	Certification:	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place of Injur	ry - At home, farm		1 Yes 2 Office		Location (St	reet and Num	ber or Rural	Route Number,				
ğ	Ö	s after bl Dire	Certi	4 Homicide determine	building, etc.	(Specify)	,			City or Town	, State)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Zowan, William		To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page		Check only 2 2 Medical Ex	Physician: To the best of aminer: On the basis of a	f my knowledge,	death occurred at	the time, date a	nd place, and	d due to the ca	tuse(s) and m	anner as sta	ated.				
9		the P thin 24 the F mplet	Medical	one) 29b. Signature and title of certifier	and manner stat	ed.		License number									
		To		1 Gund	wholm	M.D.		2180	ri		9d. Date signe						
	7	-7		30. Name and address of person wh	o completed cause of de	ath (Item 23a) (T	one Print)					13, 2	006				
	1	5		9-5-PRABIT	0 M - D. 32. Redistrat 8 2006 1864	2336	YONK	NOAD	Tiv	4021	ا بدر	40	21093				
		Sta Registr		31. Date filed (Month, Day, Year)	32. Readstrain	r's Signature	Coole										
	25		100	MALL	O LOOP KING	t-dear at a	- 1										

			1 - For State Registrar		of Marylar	-	artmen rtificat			Mental H	Reg. No.	006	15677
	Physici /Medic		Decedent's Name (First, Middle MANN			R	OSENT	AL		2. Date of D Month	Day	2006	3. Time of Death 6:50 PM
	Examin		4a. Facility Name (If not institution SINAL HOSPIT	AL OF	BALTIM		BAL	TIM				nty of Death	N/A
	Funeral Director		5. Social Security Number 113-36-3618 Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	7. Age (In yrs. 92		Months Months		If Under 24 H Hours Mi		1914	9. Birthp Coun	lace (State or Foreign POLAND
	h the Maryland r 28a-f show	tor	10a. State 10b. County	LTIMORE	10c. C	ity, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
14	with the 3e or 28a	Funeral Director	10e. Street and Number 32 STRIDESHAM	COURT		-	10f. Zip	Code	212	09	10g. Citizen	of What Coun	itry?
MANNY	36 s after deatl , or itams 2	y Funera	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	li Yes, G	edent Ever in U orces? 2 X No ive	J.S. 13.	Was Deced If Yes, spec		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	lo- 14. F	Race - Americ Black, White, cify:	
~	d 21215-0036 filad within 72 hours after death with the Maryland Hygione. Hygione. Arther then "naturel", or itlams 23e or 28e-f show ont, it a Medical Era nill er nature be mailfied at	Completed by	15. Deceden	t's Education st grade completed)		(Give		rk done d se retired	ation luring most of w	vorking		f Business/Inc	·
Roselhal	and 21 be filad wil ntal Hygien ad other th	Be	17. Father's Name (First, Middle, SHMUEL	Last)		ROSEN	RIETO	K	18. Mother's N	ame (First, Middl		RY STO	SCHWARTZ
3	Maryland d 2 should be fill th and Mental H; 77 is marked oth traumatic even	To	19a. Informant's Name/Relations		TED	19b. Maili	ng Address		and Number or	Rural Route Numi			Code)
	an an Her		ZIPORAH SPIGE 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 □Removal from	20b.	Place of Dispo cemetery, cre TH TFI	osition (Nan matory or o	ne of ther plac	e)	- BALTIM Date /17/2006	20c. Locatio	D ZIZUS In - City or To DLAWN ,	wn, State
	Baltimore permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service		DC.	2	2. Name an	d Addres	s of Facility S	OL LEVIN ROAD -	SON & E	ROS.,	INC.
	Physician		23a. Part1 B ter le disease, shock, r he rt failure. List Immediat Cause (Final disease or condition		caused the dea each line.	th. Do not en	ter the mod		g, such as card			- VIII 11	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	b. CON	(or as a consecutive of the cons	VE HE	ART	FAI	LURE				
	Division of Vital Records, P.O. Box 68760, for the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after data. To the Funerel Director: After this certificate has bean signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S . ATA	(or as a consection of the con	BRILLA	TION						
	P.O. Box 68 nat the death certifica by the attending pheletached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregn birth 2 - Fet: nant at time of common of the common of t	al death 3[⊒Ectopic pr ⊒ Other <i>(sp</i>					Date of delive Month	ry Day Year
	cords, P.O. wrequires that the debaan signed by the should be detached	by	Part II. Other significant condition ACUTE RENAL	FAILURE		sulting in the u	ınderlying c	ause give	en in Part I.		tobacco use co Yes 2 ☐ No		e cause of death?
	I Reco The law re ate has base	Completed	CORONARY AR	tery Dis	EASE					24a. Wa auto perf 1 Yes	s an 24t opsy formed? 2 No	prior to con death?	osy findings available inpletion of cause of
	of Vital F Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medica examiner? 1 \(\text{Yes} \) Yes	Hospital:	•	ER/Outpatie			er: 4 🗆 Nursing	eath (Check only	sidence 6 🗆 C)
	Division of Vital Records, to attending Physicien: The law requires the after death. Director: After this certificate has bean signed in by the funeral director, page 2 should be death.	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	gation not be 28e. Place	e of Injury - At h	28b. Time of Injury	М		at ? ∕es 2 □ No	28f. Location	(Street and Nur		l Route Number,
	Divi: To the Hospitel or At within 24 hours after to the Funerel Direct completely filled in by	edical Ceri	29a. Certifier 1 Certifyin (Check only 2 Medical	ng Physician: To th	e best of my knoosis of examin	owledge, deat	h occurred	at the tim	e, date and pla inion, death oc	ce, and due to the	cause(s) and	manner as sta e, and due to	ated. the cause(s)
	To the within 2 To the complex	Med	29b. Signature and title of certific	^ V	ner stated.			License	number 1959		29d. Date sign		Day, Year)
	7		30. Name and address of person	who completed cau D. 2401	se of death (Ite.			BA	LT (MOR	E MD	21215		
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign	ature	mes						

		1 - For State Registrar	State	of Maryla	ind / Depa <i>Cea</i>	artmen <i>rtificat</i>				_	giene Reg. No	2 U I	96	156	78
Physic	ian	Decedent's Name (First, Middle,	Last)							2. Date of De.		V	Year	3. Time of	
/Medi	cal	Charles Robert	Stern							May 18		06		7:00	Αм
Exami	ner	4a. Facility Name (If not institution, 331 Leeanne Road		imber)		ESS		Location of	of Death			County o	of Death .more		
Funeral			S. Sex	7. Age (In yr	s. last birthday)	If Under	-	If Under	24 Hrs.	8. Date of Birt	th		9. Birthp	lace (State or	r Foreian
Director		212-36-3872	1 ⊠ M 2□F	66	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept. 3	y. Year) 193	39	Mary	try)	
pu .	1	Usual Residence of Decedent 10a. State 10b. County		100	City Town or Lo	cation								0.4 1	
laryla •hov	ŏ	1.5.5.0									10d. Inside City Limits 1 ☐ Yes 2 ☒ No				
the N	ect	Maryland Baltimore Essex 106. Street and Number 106. Zip Code 10									10a Cit	izon of M	/hat Coun		
ath with the Marylar s 23a or 28a-f ehow unt be nutified at	ā	331 Leeanne Road	21221					-	S.A		uy:				
-UU36 hours after death with the Maryland turel; or items 23a or 28a-1 show al Exantituer rotal be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13					ent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - American Indian,			
or its	E	1 ☐ Never Married 2 ☐ Marrie	Armed F d 1 XXes If Yes, G	2 No	957-	fYes,spec 1 □ Yes :		n, Mexican	n, Puerto F	Rican, etc.)			k, White, (etc.	
ING 21215-UU36 be filed within 72 hours after dea tal Hygiene. d other then "natural", or items event, the Medical Exprinent III	d by	3 ☐ Widowed 4 ☼ Divorced	Year or I		501							Specify:	Wh	ite	
13-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation <i>luring m</i> os	t of workir	ng	16b. K	ind of Bu	siness/Ind	dustry	
21215-0036 d within 72 hours aft giene, r then "natural; or	mc dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		ity C					7) 1 1 	o Ma	nufa	cturer	
Hygid C	BeC	17. Father's Name (First, Middle, La	est)] Quai	icy C	Onci		er's Name	(First, Middle,				ccarer	
	To B	Lawrence Theodo:	re Stern					Viole	et Ha	rmis					
re, Maryl8 s 1 and 2 should f Health and Mer Item 27 ie marke other traumatic	-	19a. Informant's Name/Relationshi	o (Type, Print)		19b. Mailir	g Address	(Street a	ind Numbe	er or Rura	Route Numbe	r, City o	r Town, S	State, Zip	Code)	-
C = 14 C		Robert Stern (Sc	n)						e, Ba	ltimore	e, M	aryl	and 2	21 22 1	
O 0 - L		20a. Method of Disposition 1 ☐ Burial 2 ☑2remation 3	I. □ Removal from	State 20b	Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Lo	cation - (City or To	wn, State	
Baltimore, permit. Pages 1 ar Dep. ritment of Hear Imp. rient: if item any njury or othe		4 □Donation 5 □ Other (Spe	icify)		yview C									, Mary	land
Sall sermit Depur mpor mpor my n		21 Signature of St. car II S Invice Li	censee		22	. Name an	d Addres Bru	s of Faculity	nski	Funera	l ho	me,	P.A.		
2 40260	(407 C) Ld F	Caste	rn Av	renue.]	Esse	x, M	aryl		
		23a. Part 1 Enter the disease, or coshook, or heart failure. List or	nly one cause on	each line.	ath. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory ar	rest,		İ	Approximate Interval Betw Onset and D	reen
Physician /Medical		Immediate Cause (Final disease of condition resulting in death) a. Multiple Myeloma										1	O JEA		
Examiner			0.	(or as a cons	7									1 11	
	ē	Sequentially list conditions, if any, leading to immediate	Mr.	(or as a conse	equence of):				_				-	Jen	15
ansit	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-515						10 year				0.5		
exec an an rial-tr	Examin	resulting in death) Last	0.	(or as a conse										O GC	7/3
icate be executed physician and street transitions.	dical		d											1550	
	0	IF FEMALE:													
death certifications as attending of for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		birth 2 Fe	tal death 3	Ectopic pre	egnancy				2		of delive	•	
	/slc	1 Yes 2 No	4∐Pregi 9∐Unkn	nant at time of lown	death 5	Other (spe	ecity)					Mon	ırı :	Day Ye	ear
dS, F.C. BOX of irres that the death certification is signed by the attending doe datached for use as		Part II. Other significant condition	s contributing to d	leath but not re	esulting in the ur	nderlying ca	aura auva	n in Part I		23e Did to	haccou	se contril	bute to the	e cause of de	ath?
Ords, F.O. requires that the een signed by th hould be datache	d by		- commoduring to c		Journal of the Co	idonying de	idae give	ii iii Faiti.			es 2[No.		ably 4 ⊟Ur	
> 00	Completed											1			
has de la	dmo									24a. Was a autop perfor	sy	pr de	ere autop for to com eath?	sy findings a pletion of car	use of
VICAL F iclan: Th certificate rector, pag	ပိ	25. Was case referred to medical								1 ☐ Yes	38 No	1[☐ Yes	2 No	
VISION OF VITA Attending Physician: r death. ector: After this cartific by the funeral director.	o B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3□ DO	Othe	_		Check only or					
on or ding Phys th. : After this funeral dir	L L	27. Manner of Death	28a. Date	of Injury	28b. Time of		Bc. Injury	at		8d. Describe h) 	
ath.	atlo	Natural 5 Pending 2 Accident investigation	tion	ith, Day Year)	Injury	М	Work 1 □ Y	? Yes 2 □ N	No						
JIVISION Tor Attending after death. Director: After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	et, factory	office		2	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
ital o	Cer		7)	ing, etc. (Spec											
DIVISIO To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A completely filled in by the t.	edical	(Check only 2 Medical E)	Physician: To the aminer: On the b	asis of exami	nowledge, death	occurred a	at the time	e, date and inion, deat	d place, ar	nd due to the o	ause(s)	and man	ner as sta	ited.	
To the within 2 To the I	Med	one) 29b. Signature and title of certifies	and man	ner stated.	//		License								
7 × 5 0		200. Signature and time of certified	1 1	11					51				(Month, D		
-1		30. Name and address of person wh	much	er h	am 22a\ /T	Print\		0 0	//	1	10.	7 / 2	, 20	200	
5+1		M. AUERBACH		philnos		Ps :	# 5	314	Ro	Homes	10	mn	21	237	
Sta	ite	31. Date filed (Month, Day, Year)		Registrar's Sign			-		~~		1-			•	
Regist	rar	M//V 1 0 21	nne E		4 dia	18 8									

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Frederick William Scharff 2006 9:45 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Center Dundalk Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Year) | Min. | March 3,1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1∭M 2□ F 86 Yrs. 705-12-6321 South Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1X Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Bonsal Street 21224 USA filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates: 44-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Laborer 10 Foundry 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liqury or other traumatic event ODE. 18. Mother's Name (First, Middle, Maiden Surname) Be Henry William Scharff Gladys Lorena Lamb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara C. Scharff, Wife 1308 Bonsal Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 05/18/06 Baltimore, Maryland 21. Signature of Funerat Serviced icensee
Thomas Gregor ^{22. Name and Address of Facility} Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) 0 **Physician** /Medical Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ysician and e burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Be Completed by Physician/Medical anding p IF FEMALE: 23c. tf yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part tl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILIRE 23e. Did tobacce use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 1 ☐ Yes 2 ☐ No tor: After this certific the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Medicai Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Naturai 5 Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 Tyes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature ap 29d. Date signed (Month, Dey, Year) molered Cays (of death Mem) 23a) (Type Plus) _ A 31. Date fited (Month, Day, Year) 32. Registrar's Signature State Registrar

2006

			1 - For State Registrar	State o	of Marylan		artmen rtificat			and M		giene Reg. No.	006	15680		
	Physicia	- 	1. Decedent's Name (First, Middle								2. Date of De Month		Year	3. Time of Death		
	/Medic		Catherine Mar:								May	15°,	2006	11:03AM		
	Examin	er	4a. Facility Name (If not institution						Location o	f Death		4c. County of Death				
	- Funeral	Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)							olis If Under:	24 Hrs.	8. Date of Bir	Anne Arundel				
	Director	107 26 1000 10M MTE 71							Hours	Min.	May 7	y, Year) 1935	M	9. Birthplace (State or Foreign Country) Missouri		
	pu »		Usual Residence of Decedent		100 Cit	/. Town or Lo	antina									
5-0036 72 hours after death with the Maryland	ahov	2	10a. State 10b. County	A 1 - 1										10d. Inside City Limits 1 ☐ Yes 2 ☐XNo		
	28a-f	Directo	Maryland Anne 2	Arundel		Arnolo	1. 10f. Zip	Code				10a Citize	n of What Co			
	3a or											109. 01120	USA	outiny :		
	death	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex							gin? (Spe	cify Yes or No	Race - Ame	erican Indian,			
õ	or Its		1 ☐ Never Married 2 🂢 Marr		2 🗓 No		1 ☐ Yes		Specify:	, rueno i	nican, etc.)	į.	Black, Whit			
IZIS-UUSB	be filed within 72 hours after death with the Marylan id elygiane. Hygiane, determines or 28e-1 show to ther than "natural, or Itama 23e or 28e-1 show avant, the Madical Examinar must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:					ent's Usual Occupation					Specify: White			
Ċ	in 72 in 72	Completed	(Specify only highe	st grade completed)		(Give	kind of wor DO NOT us	rk don e d	urina most	of worki	ng	16b. Kind	of Business	/Industry		
7 7	d within giene. r than "	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Ant	tique	Dea]	ler			Ant	iaue (Quilts		
and	be filed tal Hygi d other avant, I	BeC	17. Father's Name (First, Middle,	Last)						r's Name	(First, Middle,					
<u>a</u>		10	Allan Gray M						Mar	arie Ennis						
Aar 2 sho	ges 1 and 2 should t of Health and Mer If item 27 is marks or other traumatic		19a. Informant's Name/Relations								l Route Numbe					
e,	1 and 1 Health em 27 ther tr		Terry C. Smith	, Husband	20h P	520 Nace of Dispo			Circle	e Ar	nold, M			012 Town, State		
More	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from	State	ametery, crei	natory or o	ther place		ΛΕ /1.	100					
Saitill	artme ortani Injury				Met	ro Cre						Balti	more,	Maryland		
ñ	Depa Impo eny l		21. Signature of Juneral Service Thomas Green	Por			remat 299 Fr	tion eder	Soci ick	ety (Road	Ot Mary Baltim	land	Inc. Marvla	and 21228		
	# To		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	. Do not ent	er the mod	e of dying	, such as	cardiac o	r respiratory ai	rrest,	. ACLL y II	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition		Ventr	icul	ai	An	mit	hn	ia			Onset and Death		
Ε	_/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Onset and O													
		-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													
	uted 3 ansit	Examiner	Cause (Disease or injury													
<u>_</u>	be executed icien and burial-transli	Еха	that initiated events resulting in death) Last	Due to	(or as a consequ	uence of):										
2/00	cate be executed physicien and the burial-transit	dical		L d												
õ	death certificate e attending phys id for use as the	Med	IF FEMALE:	00 11												
X Q Q	attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 mooths? 1 Vec. 2006 4 Pregnant at time of death 5 Other (specify)											ate of delivery onth Day Year		
ecords, F.O.	the d	nysic	1 □ Yes 2 1 No 9 □ Unknown	9□ Unkn		adii 3	J Other (sp	өспу)								
	es that the death certific igned by the attending p be detached for use as	by P	Part II. Other significant condition	art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did to	tobacco use contribute to the cause of death?				
	w require been sig should b									-	1 Yes 2 1 No 3 Probably 4 Unkr					
ပ္မ	≥ <u>0 0</u>	Completed								24a. Was autop	utopsy findings available completion of cause of					
	Physician: The lav this certificate has ral director, page 2	Con									perfo	rmed? 2 No	death?			
ION OF VITAL M	Iclan certifi ector	Be	25. Was case referred to medica examiner?	Hospital:						of Death	ath (Check only one)					
	Phys r this raf dir	2	1 Inpatient 2 FHOutpatient 3 DOA 4 Nursing								ome 5 Residence 6 Other (Specity) 28d. Describe how injury occurred					
	ding F th. : After s funera	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No								20d. Describe now injury occurred					
UIVISION	Atter	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office							2	28f. Location (Street and Number or Rural Route Number,					
5	s afte	Cert	4 ☐ Homicide building, etc. (Specify)								City or Town, State)					
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical	29a. Certifier (Check only (C										s stated.			
	thin 2. the f	Medi	one) 29b. Signature and title of certifie	and man	ner stated.			License								
)	7 × 7 8		1 4R 1A1C	1017						04		LOU. Date S	igited (Mont	h, Dey, Year)		
/			30. Name and address of person	who completed care	se of death (Item	23a) (Type		002	441	0 (21	12			
5	'		Dr. Blakeslee 479	Jumpers Hold	e Road Suit	ite 304		na Par	k, Mar	yland	21166		•			
Í	Sta		31. Date filed (Month, Day, Year)	32/F	Registrar's Signat		well !									
5	Registr	ar	MAY 1 8	ZUUB E	we to	400	A. Co.									

			ricase	State of Mar				-	iene	
			1 - For State Registrar	Otate of Mai	-	rtificate of			eg. No. 2006	15681
	* * *	198	Decedent's Name (First, Middle, La	st)				2. Date of Dear	th	3. Time of Death
(A(*)	Physicia		Domin I.	Schneider				May 13	2006	10:45 A ^M
	/Medic Examin		Doris L. 4a. Facility Name (If not institution, given	e street and number)		4b. City, Town,	or Location of Death		4c. County of Dear	
*	**************************************		4313 Cortez Ro				timore		Anne Arı	
	Funeral		5. Social Security Number 6. \$ 214-20-4509	Chr. offic	(In yrs. last birthday 80 Yrs.	Months Days		8. Date of Birth (Month, Day April	9. Bird (Co. 2. 1026 M.	hplace (State or Foreign
27	Director		Usual Residence of Decedent		80 113			April .	5,1920 Ma	aryland
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	e-1 e	ctor	Maryland Anne	Arundel	Baltimo	re				1 ☐ Yes 2 🛣 No
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	
	eth w	Funeral Director	4313 Cortez Road	12. Was Decedent Ev	i- 11.6		1225		U.S.A	
	ltem Item	-un-	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Yes, specify Cut	Hispanic Origin? (S oan, Mexican, Puert	o Rican, etc.)	Black, Whit	
980	urs at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	√hite
2-0	within 72 hours after deeth with the Maryland ene. than "natural", or Iteme 23a or 28e-f ehow the Medical Exactivat mark be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	edent's Usual Occu	during most of wor	rking	16b. Kind of Business	Industry
2	hen.	щĎ	Elementary/Secondary (0-12)	College (1-4or 5+)) life.	DO NOT use retire	ed)			0 1 1
5	Hygie Hygie thert nt. Ith		12 17. Father's Name (First, Middle, Lasi	N/A	Ca	feteria		ne (First, Middle, I	A.A. Count	y Schools
Maryland 21215-0036	d be ental ked o	To Be	William	,	Koug1		Etta	, , , , , , , , ,	,	Kern
ary	shound M	-	19a. Informant's Name/Relationship	Type, Print)		ing Address (Stree	t and Number or Ru	ıral Route Number	; City or Town, State, 2	Zip Code)
Ž	and 2 ialth a ialth a ialth a ialth a in tra		Michael E. Fogus	(Grandson)	8854	Winding	Hollow W	ay Spring	gfield Vir	inia 22152
ore	of He fitem		20a. Method of Disposition 1 🛣 Burial 2 🗀 Cremation 3 [Removal from State	20b. Place of Disp cometery, cre	osition (Name of matory or other pla	100)	Date	20c. Location - City or	Town, State
Ē	Pag ment lant: I		4 □ Donation 5 □ Other (Special	(y)			Cem 5/17		Crownsville	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28e-1 show spiringly or other traumatic event. It a Medical Enaminating must be notified at once.		21. Signature of Funeral Service Lice	nsee	M	2. Name and Addr CCully-P	ess of Facility Olyniak F	uneral Ho	ome, P.A.	yland 21225
90	40204		23a. Pary. Enter the disease, or con	polications that caused the	he death. Do not en	37 East]	Patapsco	Ave. Bali	timore, Mar	yland 21225 Approximate
	Standard Standard		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	١.			or roophatory and	,	Onset and Death
15	Physician /Medical		disease or condition resulting in death)	a	consequence of):	Diseas				years,
*	Examiner		Constitution line and divine	b	,					
. 17	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	eansequence of):					
17	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dun to (or or o	consequence of):					
760,	icate be executed physicien and s the burial-transit	caj E		Due to (or as a	consaquanca or).					
687				_ d						
Box	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be delached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		□Ectopic pregnanc			23d. Date of del	ivery
B.	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at til		Other (specify)	-y		Month	Day Year
P.O.	at the d by the etach	Phy	9 Unknown				and a Broad	OO Diday		- the accuse of death?
	e law requires tha has been signed je 2 should be de	à	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gi	ven in Part I.		bacco use contribute to es 2□No 3□Pr	othe cause of death?
Vital Records,	been Should	Completed	Hyperlipideor	ià				24a. Was a		
Rec	The law ate has page 2 a	ig m	179 pecapitation					autops perforr	prior to death?	itopsy findings available completion of cause of
tal			25. Was case referred to medical	. —			26 Place of Dec	1 ☐ Yes : ath (Check only on	2 ☐ No 1 ☐ Yes	2 1 No
	Physiclan: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Ot	hor		ence 6 ☐Other (Spe	cify)
0	ng Ph Iter th neral	Ľ.	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (of 28c. inju	ry at	28d. Describe ho	ow injury occurred	
Sio	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not I	10			Yes 2□No			
Division of	Il or Attend after death Director: A	Certification:	4 Homicide determined		y · Al home, farm, s (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
	ours a		29a. Certifier 19 Certifying P	hysician: To the best of	my knowledne dea	th occurred at the t	me date and place	and due to the c	ause(s) and manner as	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exa	miner: On the basis of a	ixamination and/or ii	nvestigation, in my	opinion, death occu	irred at the time, d	ate and place, and due	to the cause(s)
	To the l within 2 To the I	Me	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (Monte	h, Day, Year)
	_		Mélevare la	amoun		D13	667	(D5-15-	2006
	10		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	, Print)	e colon Q.	S. May	land 2106	1
	\		31. Date filed (Month, Day, Year)	320 Registrar	's Signature	. So	o Wien D	They are	200	ſ
	Sta Registi			06 Registrar	's Signature	well				
100	t.		MELLOC	UU RATE STORES	3- 17		<u> </u>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

			State of	r Marylan		epartmer C <i>ertifica</i> :		ieaith and i <i>Death</i>	_	gierie Reg. No.?	16 15	682
			1. Decedent's Name (First, Middle, Last)	1		,			2. Date of De		3. Time	e of Death
	Physici /Medio		Li LLIAM	CHUI	MA	7			May	17 2		22 A.M.
- Control	Examir		4a Facility Name (If not institution, give street and nur					4b. City, Town, or I	ocation of Deat			
			Genesis Eldercare			. Millede	- 1 Van-	Catons			imore	
	Funeral		1□ M 2□ TE	7. Age (In yrs. I	last birtho Yr:	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Big (Month, Da	th ay, Year)	9. Birthplace (State Country)	e or Foreign
	Director		214 46 0882	71					Aug. 7,	1934	Maryland	
	/land		10a. State 10b. County	10c. City	, Town o	r Location						City Limits
	Man	ğ	Maryland N/A	Ва	altir	nore					1 X Y	es 2□No
	or 28	Director	10e. Street and Number			10f. Zi	Code	20		10g. Citizen of V	/hat Country?	
	23a ust b	a	1227 Cleveland Street				212			U.S.		
020	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-f show he Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 12. Was Dece Armed Fo 1 □ Yes, Give Year or Divorced	2¥⊡No e	S.	13. Was Dace If Yes, spe 1 ☐ Yes		lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Blac	e - American Indian, k, White, etc. : White	1
9-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. D	ecedent's Usu	al Occup	ation during most of wo	rkina	16b. Kind of Bu	siness/Industry	
21	within 7 ene. than 'r he Med	npie	Elementary/Secondary (0-12) College (1	-4or 5+)				during most of word)	3	0	II	
2	77 74 14 14 14 14		3rd		по	memake:	L	18 Mother's Nar	no (Firet Middle	OWII , Maiden Surnam	Home	
anc	ed at a	Be	17. Father's Name (First, Middle, Last) Richard Long						ian Swa		0)	
2	d 2 should be f th and Mental h 7 is marked ot traumatic eve	2	19a. Informant's Name/Relationship (Type, Print)		19b. N	Mailing Addres	s (Street	and Number or Ru			State, Zip Code)	
N S	Trans.		Richard Rineholt / son		770	3 Padd	ock '	Way Bal	timore,	Marylan	d 21244	
re,	s 1 and st Health item 27 other tr	Ì	20a. Method of Disposition	20b. P	lace of D	isposition (Na crematory or	me of other pla	ce)	Date		City or Town, State	
Ë	Pages nent of I int: if ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 3 ☐ Donation 5 ☐ Other (Specify)	State		/ Crema			5/22/06	Baltimo	re, Maryl	.and
Baltimore, Maryland 21215-0020	permit. Pages Department of the important: if ite any injury or of pages.		21. Signature of Funeral Service Licensee								rvice, P. Maryland	
			23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death ach line.	n. Do not	t enter the mo	de of dyi	ng, such as cardia	or respiratory a	arrest,	Approxin Interval E Onset an	Between
V.	Physician /Medical Examiner		Immediate Cause (Final disease or condition a	Acut	i	Ron	al	failu	l		WK	1
		ا و ا	resulting in county	Due to (o	rasaco	nsequence of	:					
A	uted d ansit	Examiner	Sequentially list conditions	Due to (o	as a co	nsequence of)						
ان فر	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use es the bunal-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								į	
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Вох	eath certif attending for use ex	ian									!	
	that the de ed by the a detached	Physician/M	Part II. Other aignificant conditions contributing to de			he underlying	cause gi	ven in Part I.			ntribute to the caus	se of death?
, P.O	that the		- Malvym	4.00				<u>n</u>	1	Yes 2□ No	3 Probably 4	CONKIONII
Records,	w requires that been signed I should be det	d by	- Malvertie to	uluni	_				24a. Was	an autopsy ormed?	24b. Were autops available prid	sy findings or to
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æ	The law te hes rage 2	E	- J// CVA						90	You 2 Miles	1 ☐ Yes 2	2□ No
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sio	Attending or death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	of laium. At he	oma farm	M street facto		Yes 2□No	28f. Location	Street and Numb	er or Rural Route N	lumber.
Division	or At efter of Direction by	ertif	determined 200. Flace	of Injury - At he ng, etc. (Specify	y)	i, street, lacto	ry, onice			wn, State)		
_	To the Hospital or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edical Certification:	29a. Certifier (Check only one)	asis of examina	wledge, o	death occurred or investigatio	at the ti	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the caus	se(s)
	ithin to the other of the or the or the	Med	29b. Signature and title of certifier	ALL	mal	wp 25	c. Licen	se number		29d. Date signed	d (Month, Day, Year	r)
	6 11 € 1		Dillow A. M)	My		03	6942	,	May 1	7,200,	6
	3		30. Name and address of person who completed caus	se of death (Item	1 23a) (T	ype, Print)		. ,		5		
	V	2	1009 Frederick R	à., Co	tors	rille	, M	0 2/22	-8			
	St	ate	31. Date file (Month, Day, Year) 33/11	egistrar's Signa	ture	South						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 16, 2006 Angela Marie Sanderson May 9:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 415 Valley Meadow Cir. Apt. T2Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗓 F Yrs. Director 219-44-7903 60 Oct. 8, 1945 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event, it a Madical Examinar must be notified at 1 ☐ Yes 2X No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Valley Meadow Cir. Apt. 21136 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Secretary Medical N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Alcinda Blickenstaff Amos Daniel Peightel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 415 Valley Meadow Cir. Apt. T2 Reisterstown, MD 21136 Walter Sanderson/Husband Important: If ite,
eny injury or oth 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metro Crematory or other place) 1 □ Burial 2 X Cremation 3 □ Removal from State May 17, ^¹ 4 □ Donation 5 □ Other (Specify) 2006 Baltimore, MD 21. Signature of Fune at Se 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley ce Dicensee 10 W. Padonia Road Timonium, MD 21093 Flag1e J. Michael 23a. Part1 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death state (aucino ma a) C Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 → 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 2 T No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Mesidence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 dentifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: Of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Exeminer: Of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) esd (over though pikes) lisury and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mand Sher may 4000 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Year 5:45 P. M MAY **Physician** SEWARD 13, SIGMOND /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 8112 HALTON ROAD TOWSON 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-08-1943 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **X**XM 2□ F 63 213-42-4560 Yrs. MARYLAND Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or iteme 23s or 28e-f ehow any injury or other traumatic event, the Medical Examiner must be routilised at 2008. TOWSON 1 Yes XXNo MD. BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 ROAD U. S. A. 8112 HALTON Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status XXYes 2 No 1966 If Yes, Give Year or Dates: 1968 1 Never Married XX Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working REAL ESTATE Cotlege (1-4or 5+) YEARS Elementary/Secondary (0-12) **ESTATE APPRAISER** REAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SIGMOND STANLEY SEWARD R. VIRGINIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8112 HALTON ROAD, TOWSON, MARYLAND, 21204 JOANNE M. SEWARD (WIFE) 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State DULANEY VALLEY M.G. 05-19-2006 TIMONIUM.MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R.G.RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
3 12 UCCVS Immediate Cause (Final disease or condition resulting in death) Hdenocarcinoma Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes XX No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KNesidence 6 Other (Specify) Hospital: 1 ☐ Yes X No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death
X Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death. 2 Accident the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours el To the Funeral D completely filled i Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier, 15, 2006 D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON AVE BALTIMORE MO 21229 900 MENES 10+1

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 8 2006

ORIGINAL

32 Registrar's Signature

		•	For State Registrar	State of M	Maryland ,	-	artment of rtificate o				iene 19. No.2 () () (5 15685
		4, -	1. Decedent's Name (First, Middle, Last)					2	2. Date of Deati	n Day Ye	3. Time of Death
	Physici /Medic		Rodopi	Smyrnio	udis					May 13,		1:45 A M
	Examin		4a. Facility Name (If not institution, give	street and numbe	r)		4b. City, Town	n, or Location	of Death		4c. County of D	eath
**			1236 Knightswoo			history a	It I Index 1 Vo	Baltin		Date of Black		timore
	Funeral		5. Social Security Number 6. Se 218-82-4725	X]M 2 🔀 F	Age (In yrs. iast 87	Yrs.	Months Day		Min.	B. Date of Birth (Month, Day, NUG 17	Year) 9.	Birthplace (State or Foreign Country)
*	Director		Usual Residence of Decedent		07		L,		P	lug. 1/	, 1310	Greece
	land ow		10a. State 10b. County		10c. City, T	own or Lo	ocation					10d. Inside City Limits
	Man	to	Md. Baltir	nore			Ba1	timore				1 Yes 2 XNo
	h the	Funeral Director	10e. Street and Number				10f. Zip Code	8		10	g. Citizen of What	Country?
	th wit	a D	1236 Knightswood	d Road				21239	9		US	A
	dea	ner	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13.	Was Decedent of If Yes, specify C	of Hispanic Or	igin? (Speci	fy Yes or No- can, etc.)		merican Indian, /hite, etc.
36	or it		1 Never Married 2 Married	1 ⊟Yes 2.≹ If Yes, Give	No		1 ☐ Yes 2 ☐ X N				Specify:	
00	72 hours after death with the Maryland naturel', or iteme 23a or 28a-1 ehow disal Examinat must be rodified at	d by	3 X Widowed 4 □ Divorced	Year or Dates		2. D						White
15-	n 72 "nat	Completed	15. Decedent's Edu (Specify only highest grad	le completed)		(Give	dent's Usual Oct kind of work do DO NOT use ret	ne during mos	st of working	7	16b. Kind of Busine	ss/industry
12	withi ene. than	mc d	Elementary/Secondary (0-12)	College (1-40	r 5+)		Homem	aker			Own	Home
D D	Hygi Hygi ent, 1	BeC	17. Father's Name (First, Middle, Last)						er's Name (First, Middle, M	faiden Sumame)	
Jan	id be entai ked ic ev	To B	Emmanuel H	landras					R	losa Ko	hler	
ary	shound N	_	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailir	ng Address (Stre	et and Numb	er or Rural I	Route Number,	City or Town, Stat	e, Zip Code)
Σ	alth a		Margo Holden/Niece	9		6734	West La	akerid	ge Rd.	New Ma	arket, MD	21774
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ f	Damoval from Stat	20b. Płace ceme	e of Dispo etery, crer	osition (Name of matory or other p	olace)	Dat	te 2	20c. Location - City	or Town, State
Ĕ	Page nent ant: if		4 Donation 5 XOther (Specify,		Greek	Ort	hodox C	em.	5/17/	06 E	Baltimore	, Maryland
Baltimore, Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-1 show any njury or other traumatic event, the Madical Examinat must be recilified at Ance.		21. Signature of Funeral Service Licens	0	/							Home, Inc.
	20729		Michaely	1 Lucs			050 Yorl				'yland 21	204
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus ne cause on each	ed the death. I line.	Do not ent	ter the mode of o	tying, such as	cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Finaf disease or condition	a Ather	rosel.	era	5,5					10 4000
	/Medical Examiner		resulting in death)	Due to (or a	as a consequen	ce of):						1
ŀ	LAUMINICI	L.	Sequentially list conditions,	b. Acrt	as a consequen		25.5					F AGALL
	pe d	Examine	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DUB 10 (01 2	is a consequen	ice oi).						,
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8760,	death certificate be executed e attending physicien and e for use as the burial-transit	alE		d								
687	ifficate ig phy: as the	Physician/Medical		d								
Вох	ath certif attending for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			75-4				23d. Date of	delivery
	death e atte	Ca	in the past 12 months?	4☐Pregnant	2 Fetaf de at time of death		∃Ectopic pregna ∃Other (s <i>pecify)</i>				Month	Day Year
P.O.	that the de ed by the detached	hys	9 Unknown	9∐ Unknown								
		ьу Р	Part II. Other significant conditions co	ntributing to death	but not resultin	ng in the u	nderlying cause	given in Part	1.	23e. Did tob	1	e to the cause of death?
ord	faw requires as been sign 2 shoułd be									1 ☐ Ye	s € No 3 [Probably 4 Unknown
ecc	has be	ple								24a. Was ar autopsy		autopsy findings available to completion of cause of
of Vital Records,	T ate	Completed								perform	ed? death	1?
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						e of Death (Check only one	9)	
7	Physicien: this certific ral director,	ဥ	To res 25 No	Hospital: 1 ☐ Inpa		/Outpatier	II 3 DOA				nce 6 Other (S	Specify)
ň		inol:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of fr (Month, L	Day Year) 28	lb. Time o Injury		njury at Vork?		d. Describe ho	w infury occurred	
isic	ten Jeatl tor; the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	280 Place of I	Inium - At home	form of	M 1 reet, factory, office	☐Yes 2☐		f Location (St	not and Number of	Rural Route Number,
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_	spitel ours neral filled	O	29a. Certifier 1 Certifying Phy	/sician: To the be	st of my knowle	dge, deat	h occurred at the	e time, date ar	nd place, an	d due to the ca	use(s) and manner	r as stated
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exam one)	iner: On the basis and manner	of examination	and/or in	vestigation, in m	y opinion, dea	ath occurred	I at the time, da	te and place, and	due to the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifier	7-1	-01			ense number	For	29	d. Date signed (M	
)) June (. V.	clary	1		2	3094			5/15	106
			30. Name and address of person who o	ompleted cause o	f death (ftem 23	Ba) (Type,	Priory 11	_(- 0	() \	
	12		30. Name and address of person who constitution of the state of the st	harles	Stree	t	12011	ا مو ن مام،	e con	0 7	1207	
	Sta		31. Date filed (Month, Day, Year)	Regis	strar's Signature	Las	de					
E.	Registi	ar	MAI I 8 200	TO RECEIVE	See See	MA						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Year **Physician** 3:15PM SUSSMAN 2006 ETHEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospital Baltimere 8. Date of Birth 5 1 904 9. Birthplace (State or Foreign Country) RUSSIA Age (In yrs. last birthday, If Under 24 H 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F 101 213-50-0825 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f show 1 V Yes 2 □ No Director N/A BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA 4001 CLARKS LANE #208 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ 3 X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If Item 27 is marked other th
any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUBIN DITLOW DORA **JOSEPH** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4001 CLARKS LANE #208 - BALTIMORE, MD 21215 GLORIA SUSSMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FRIEDEL MARYLAND LODGE 5/17/2006 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Party. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Pneumania Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 2 ☐ Fetal death Month Dav Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 TYes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an themia autopsy performe 1 Tyes 1 ☐ Yes No No of Vital Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 k npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cuttifier ŝ 29b. Signature and title of certifier 29c. License number RES-000 May 15, 2006 Hospital of Baltimore

State Registrar 31. Date filed (Month, Day, Year)

MAY 1

8 2006

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WADHAWAN

32. Registraris Signatur

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 17, 2006 Medical Examiner Turner 0912 hrs Lee Robert 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** N/A 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** Age (In vrs. last birthday) Months Day: Hours Foreign Director 220-52-4536 59 June 1,1946 1X M 2 F Country) Usual Residence of Decedent Į, 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Yes 2 X No Middle River tant. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Md. Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 USA 15 Harrison Funeral 11 Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. Specify: White Widowed Divorced f Yes, Give Year Yes 2 X No specify <u>≥</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ **Baltimore, MD 21215-0036** Beth. Steel Steel Worker 12 yrs. 4 yrs. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Helen Turner Marvin Turner Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Middle River md. 21220 John Turner son 1410 3rd. Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 18 May Bayview Crematory Baltimore mportant; Donation 5 Other Specify 2006 Signature of Funeral Service License Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Approximate Interval Physician Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Gause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year Day past 12 months? After this certificate has been signed by the attendi funeral director, page 2 should be detached for use Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 XUnknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 ✔ N 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: 1 V Natural Pending Yes 2 No To the Funeral Director: completely filled in by the 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Che Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Si 29c.License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2006 cause of death (Item 23a) J. Laron Locke, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DUPLICATE

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:50 p^M May 16, 2006 Catherine Virginia Taylor /Medical 4b. City, Town, or Location of Death 4c County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1905 Madison Rd. Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 216-08-9244 84 Yrs Dec 19, Director W.V. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in then "natural", or Items 23s or 28s-f show the Medical Examinar must be nutified at 1 ☐ Yes 2 ☑ No Md. Baltimore Dundalk Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 1905 Madison Rd. 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status within 72 hours after 1 ☐ Yes 2 X No ff Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ⋧ 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Home Housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental it of Health and Mental Ernest Clarence Ours Virginia Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Singleton 1905 Madison Rd. Dundalk Md. 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 20, Department of Important: If eny injury or pace. Critestown Cem. West Virginia 2006 22. Name and Address of Facility
Connelly Funeral Home Of Dundlak
7110 Sollers Point Rd. 21222 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. (Jo not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure) List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼ No 3 Ectopic pregnancy signed by the atte Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? Yes 2 No Yes To the Hospital or Attending Physician: Nwithin 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier n. D. 30. Name and address of person who completed cause of death (flem 23a) Type, Print) Acad #200, Bel Air, MD 21014 My wan orn 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State MAY 1 8 2006 Registrar

Please Type or Print in Black Indelible Ink

Charles Emory To		ney - For State	State of Ma	aryland		rtment of tificate of	Health and	d Mental H		201	16 1566
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, M Charles	iddle,Last)	En	nory		Toome	 ey	2. Date of Death Month May 16, 20	Day Year	3. Time of Death 1530 hrs
A second		4a. Facility Name (if not instit		and numbe	r)	í	4b. City, Town, or Catonsville	Location of Dear		4c. County of Dea Baltimore Co	
Funeral Director		5. Social Security Number 220-04-1643	6. Sex		ge (In yrs. la	ast birthday) Yrs	If Under 1 Year Months Days			h(MM/DD/YYYY) 9. B Fore 1968 ^C	
and show any ince.	Ī	Usual Residence of Decedent 10a. State 10b. Cour Maryland Ar		le1		Town or Locati					10d. Inside City Limits 1 Yes 2 X No
I eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 99 Will -	0 -Brook				10f. Zip Code 211	122	10	og. Citizen of What Co USA	untry?
ত ১ টা	by Funeral		Married Ari	med Forces Yes ive Year	2 X No	1	s Decedent of His es, specify Cuban Yes 2 X No t's Usual Occupat	specify:		White, etc.	rican Indian, Black,
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	mpleted	15. Decedent's Education (in Elementary/Secondary (0-11th) 17. Father's Name (First, Michael 11 th)	12) Col	ege (1-4 o		during m	ost of working life.	. DO NOT use re		constru	
D 21215. should be filec and Mental Hy 7 is marked of natic event, th	To Be C	Ralph 19a. Informant's Name/Relat	LOU onship (Type, Pri	nt)			Address (Stree			Scott aber, City or Town, Stat	te, Zip Code)
re, M s 1 and 2 of Health If item 2		Helen C Baue 20a. Method of Disposition 1 Burial 2 Crema 4 Donation 5 Other		ther	State	Place of Dispos	ition (Name of cer	metery,	Date	MD 21122 20c. Location - City of Baltimore	
Baltimore, permit Pages I a Department of He injury or other ti		21. Signs ture of Fund all Spr 23a Part II. Enter the disease	ric Litensee) at cause	ed the death	1	Name and Address 3111 Mo	2	tallings Road Pas or respiratory arre	Funeral Hi adena MD 2 est, shock, or heart	1122 Approximate Interval
/Medical Examiner	1	failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	ase a. Ch	ronic		ic and co	caine use				Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate events resulting in death). List	use ed c.		sequence o						
), be executed sician and nurial - transit	dical Ex	Y UNPENDED	d	NDED i	tem#23a	a.27.perM	E,g855,5/2	6/06 TT			
Box 68760, e death certificate be the attending physicical for use as the burined for use a	Ĕ١	IF FEMALE: 23b. Was decedent pregnant past 12 months?		If yes, outo	ome of preg	nancy 2 Fe	etal death 3	Ectopic preg	inancy	23d. Date of delive Month	Day Year
ords, P.O. I v requires that the seen signed by the should be detached.	þ	Part II. Other significant co	nditions contrib	uting to de	ath but not r	esulting in the t	underlying cause (given in Part I.		an 24b Were a	o the cause of death? obably 4 Unknown autopsy findings available b completion of cause of
ital Reco ician: The law s certificate has	e Completed	25. Was case referred to me	dical				26.Place	e of Death (Chec	perfor 1 🗸 Yes	rmed? death?	
n of Vi ling Physi After this	ation: To Be		Hospital: 28a Pending nvestigation	1 Inpa a. Date of In (Month, Day	njury v,Year)	ER/Outpatient 28b. Time of	Injury 28c. Inju	Other ₄ Nursury at Work? Yes 2 No		Residence 6 Oth	er: Scene
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 4 Homicide	Could not be determined (S	pecify)			et, factory, office t		or Town, S		Rural Route Number, City
To the Hos within 24 h To the Fut completely	Medical		Examiner: On the and m		kamination a			n, death occurred		and place, and due to	the cause(s)
O X		30, Name and address of pe	trile (do cause o	f death (Iten	n 23a)	O.C.	M.E.		May 17, 2006	
St	tate	Laron Locke MD.	Assistant M	ledical E		111 Penr	Street, Baltin	more, MD 2	1201		
DHMH 17 Rev 1/2	trar		8 2006	Major	as A	ORIGINA	AL.				

. 6	42	State Registrar 1. Decedent's Name (First, Middle, Last)	4	Cei	TITICAT	e of L	Jean		2. Date of Dea	th	Voor	3. Time of Death
Physici /Medic		William James	s Worth	У					MA MA	Y Day 3,		1:08A N
Examin	er	4a. Facility Name (If not institution, give street a Saint Joseph Med	ical Cent	er	4b. City,	Town, or	Location o	f Death	n	4c. Coun		imore
Funeral Director		5. Social Security Number 6. Sex 1区 M 2[7. Age (In yrs. It	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 05/14	, Year)	9. Birthp Cour SC	lace (State or Foreig try)
72 hours after death with the Maryland natural", or items 23a or 28a-f ehow deal Exementer must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	0 1	Town or Lo							1	0d. Inside City Limit:
or 284	Oire	10e. Street and Number	11		10f. Zip	Code				0g. Citizen of	What Cour	itry?
ath w	rai	4720 Sayer Are Ap	F FT	2 10	_	229	i- Osia	-i-2 /C	-ii. Vaa os Na	USA	ıce - Americ	on Indian
s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. Items 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Exemples must be notified at	by Funeral Director	1 Never Married 2 Married 1 T	s Decedent Ever in U.S led Forces? Yes 2 ☐ No les, Give Ir or Dates:		was Deced If Yes, spec	offy Cubai	Specify:	, Puerto F	cify Yes or No- Rican, etc.)		ack, White,	
2 hou	ted	15. Decedent's Education		16a. Dece	dent's Usua	al Occupa	ition	of working	20	16b. Kind of	Business/Inc	dustry
within 7 ene. than "n	Completed		lege (1-4or 5+)		kind of wo		uning masi	OI WOIKII	rg .	0 -	0	
2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, Lie Ms		17 Grade 17. Father's Name (First, Middle, Last)		fire	figh	Her	19 Mothe	r's Namo	(First, Middle,	Baltim Maiden Suma	ore C	-:+ <i>y</i>
ntal H ed of	Be	Willie Worthy					1		Burris		urie)	
should nd Mer marke	2	19a. Informant's Name/Relationship (Type, Pri	nt)	19b. Maili	ng Address	(Street a		r or Rura	I Route Numbe		n, State, Zip	Code)
alth ar 27 le		Robert L. Smith J	ST.	3433	In	erdal	e Ct)	Par	dellsta	on, Mi	7 21	133
es 1 and 2 of Health a f item 27 le		20a. Method of Disposition	C	ace of Dispo	sition (Nan	ne of	1		ate	20c. Location		wn, State
Pages ment of ant: If i		1 Burial 2 □ Cremation 3 □ Remova □ Donation 5 □ Other (Specify)		rison	Fores	+	5	5/a3/	060	Justings	Mills	MD
permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		2: V	Name an	d Addres	s of Facility	Fun	eral soc			- 20
₫ D ⊆ ë d		23a, Part1. Enter the disease, or complications	riene	5	गड़ा ह	garpo	Next.	Pike,	Baltin	ore, M	D 31	Approximate
Physician /Medical		shock, or heart failure. List only one caus	e on each line. THEROSLEF						DISEA]	Interval Between Onset and Death DE.CADES
icate be executed physician and sthe burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	ue to (or as a consequue to (or as a consequ									
death certif e attending ed for use a	Physician/Med	in the past 12 months?	es, outcome of pregnal Live birth 2 Fetal Pregnant at time of de Unknown	death 3	⊒Ectopic pi ⊒ Other (sp						ate of delive	ery Day Year
gned gned be de	þ	Part II. Other significant conditions contributin HYPERTENSION	ng to death but not resu	alting in the u	inderlying c	ause give	n in Part I.			bacco use co es 2□No	ntribute to th	ne cause of death? ably 4 DUnknow
> 0.0	ojete	CMRONIC OBSTRUCTI	RIVE PULMON	IARY D	ISEAS	E			24a. Was a		. Were auto	psy findings availab
r	Completed	STATUS POST CORO	NARY BYPASS	SURG	ERY				autop perfor 1 XYes		death?	mpletion of cause of 2□ No
rsician: T s certificat lirector, pa	Be	25. Was case referred to medical examiner?				Tou			Check only or			
Physical Color	tion: To	1 Yes 2 No Hospita 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injury Work	4 190	2	ne 5 Resid 28d. Describe h			γ)
or Attending after death. Director: After din by the funer	Certification:	2 Could not be	Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factor	y, office		2	28f. Location (S City or Tow		nber or Rura	l Route Number,
To the Hospital or Atterwithin 24 hours after dewithin 24 hours after decoration 20 the Funeral Directo	Medical C	Continue (Check only one) Continue (Check only one) Continue (Check only one) Continue (Check only one)										
To the within To the	Me	29b. Signature and title of certifier			290	c. License	number		-	29d. Date sign		
1		Now It Ison	he MD			D518	352			51	14/3	2006
37		30. Name and address of person who complete					בייו וייינ	Thi ka	ADVI AN	ID OLO	C) A	8170
10		DAVID A. BRINKER,	MD 7601 (DSLER	DRI	VE.	IUMPI	ויו צונ.	HKATHL	W Ele	K14	

	1	For State Registrar	State of Maryland		nt of Health and te of Death		giene 006	15692
Physicia /Medica	n al	1. Decedent's Name (First, Middle, Li DENNIS' 4a. Facility Name (If not institution, gi	WARRE		, Town, or Location of D	2. Date of Dea		
Examine Funeral Director	-	HARBOR I-C 5. Social Security Number 6.	SPITAL CENT Sex 7. Age (In yrs. last	ER BA	LTIMORE	Hrs. 8. Date of Birt (Month, Da)	h 9. Bi	rthplace (State or Foreign ountry)
D.		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location		June	23 1961	10d. Inside City Limits
21215-UU36 d within 72 hours after death with the Maryland piene. Ir than "natural, or items 23s or 28s-f show the Madical Examination Littled at	ra D	10e. Street and Number 1214 Shellban 11. Marital Status	12. Was Decedent Ever in U.S.	10f. Zi	p Code D1325 Ident of Hispanic Origin? Ident Mexican, Poor Code (1988)		10g. Citizen of What C	
215-0036 thin 72 hours after ean "natural; or ite Madical Examine	Ď.	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest qu	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 Yes	2 No Specify:	1	Black, Who Specify:	olack
	de Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las	College (1-4or 5+)	Mail I	Distribution	Name (First, Middle,	Maiden Sumame)	
Mary nd 2 shou lith and M 27 is mar r traumat	0	David Warr 19a. Informant's Nama/Relationship		19b. Mailing Address	S (Street and Number of		nson r, City or Town, State,	Zip Code)
altimore mit. Pages 1 partment of H. portant: if iter y injury or ott		20a. Method of Disposition 1 Durial 2 Cremation 3 (4 Donation 5 Other (Spec	Removal from State Cede	e of Disposition (Na. etery, crematory or of the control of the co	other place)	Date 19-06	20c. Location - City of	Town, State
D		23a. Par Inter the disease, or cor shock or heart failure. List only Imm the Cause (Final disease or condition	pplications that caused the death. If one cause on each line.	Do not enter the mod	de of dying, such as card	Halo F	rest,	Approximate Interval Between Onset and Death
/Medical Examiner	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. PNEUMO Due to (or as a consequent	NIA				ONE DAY
S760, cate be executed by sicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. AIDS Due to (or as a consequent	ce of):				TWO YEARS
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed the hes been signed by the attending physicien and age 2 should be deteched for use as the burial-transit	Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic p			23d. Date of de Month	livery Day Year
w requires that been signed by should be dete	2	Part II. Other significant conditions SUBSTAN C	A -	ng in the underlying o	cause given in Part I.	1 Y		o the cause of death? robably 4 □Unknown
	de Completed	25. Was case referred to medical examiner?			26. Place of [med? prior to death? 2 No 1 □ Yes	utopsy findings available completion of cause of
on of ding Phys. After this funeral di	0	1 Yes 2 No 27. Manner of Death 1 Notural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Outpatient 3 DO	OA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No		ence 6 Other (Spe	ocify)
DIVISION Hospital or Attending 24 hours after death. Funeral Director: After the fune of	al Certification;	3 Suicide 6 Could not idetermined	building, etc. (Specify)	dge death occurred	at the time date and pla	City or Fow	auco(c) and manner a	a state of
To the Hospital or within 24 hours after to the Funeral Discompletely filled in	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	miner: On the basis of examination and manner stated.	and/or investigation	c. License number	ccurred at the time, d	ate and place, and due	to the cause(s)
· k	-	30, Name and address of person who	completed cause of death (Item 23	Sa) (Type, Print)	RES OOG		MAY, 11,	
State Registra	-	11. Date filed (Month, Day, Year) MAY 1 8 200	32. Registrar's Signature	Sporte	STREET, B	ALIMO	KE, NIAK	ILMIVU

		•	For Stata Registrar	State of Maryland / [Department of F Certificate of		ental Hygien	4000	15693
			1. Decedent's Name (First, Middle, Last	1 1		1	2. Date of Death	ay Year	3. Time of Death
	ysicia Aedic	- 6	ARLENE	WORTHAN	1		Month 10		1107AM
	amin		4a. Facility Name (If not institution, give		4b. City, Town, o	r Location of Death	4	c. County of Death	1
44			THROY FIC	SPITAL	thday) If Under 1 Year	If Under 24 Hrs. F		NIO	4
Fun Dire			5. Social Security Number 6. Se	711 000 -	Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, Year	9. Birthi	()
_	CLOI	ŀ	Usual Residence of Decedent				00 4/170	2/ ///	irigland
with the Maryland	4	. [10a. State 10b. County	10c. City, Tom	or Location				10d. Inside City Limits
eth with the Marylar 23a or 28a-f ehow	1	Director	ma	14 /2	Jalter	nore			1 Yes 2 No
ith th	20 90	Olre	10e. Street and Number	ICL	10f. Zip Code		10g. C	itizen of What Cou	ntry?
₽ S2	ISIN	ra	SIIU PROSI	sury .		1216		05,	H
OUSO hours after dee tural; or Items	odical Examinar n	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	13. Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 ☑ No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: P	
2-00: 72 hours 'natural',	2	ed b	15. Decedent's Edu	Year or Dates:	Decedent's Usual Occup	nation	16h	Kind of Business/In	dusta
0 72 u	ag l	Completed	(Specify only highest grad	e completed)	(Give kind of work done life. DO NOT use retired	during most of working d)	7		n
d within giene.	E M	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)	4 /1	ctical no		Hosp	ritals
other state	vent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name (n Sumame)	
Vial Menta Menta Menta		ို	fulton Wi	EWELL		Jenni	e m	abrey	
2 sho and and Is my	other traumatic		19a. Informant's Name/Relationship (Ty		Mailing Address (Street	and Number or Rural	Route Number, City		
and and lealth	hert	-	Jaunya EWell-	daughter 1	198 E.C.	rester-9	Sack	, md, 2	
0 0 0 =	or ot		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ F	Removal from State cemeter	Disposition (Name of y, crematory or other place			ocation - City or To	
t. Pag rtment rtant:	Jury	}	4 Donation 5 Other (Specify)	1 / net					Ile, md.
permit. Departm Importa	eny in		21. Signature Funeral Service Licens			ss of Facility 270			
			23a. Pairt. Enter the disease, or compl	ications that caused the death. Do n		arch Fren		e paero.	Ma, Zi 229 Approximate
			shock or heart failure. List only or immediate Gause (Final	ne cause on fach line.	M				Interval Between Onset and Death
Physic /Med			disease or condition resulting in death)	TCUTE		CDIAL	IN FAR	GTOP	246.
Exami			- 1	Due to (or as a consequence of	01):				
4	5.A	Jer.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):				
X 3 9	ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events						
be exe			resulting in death) Last	Due to (or as a consequence of	f):				
cate be executed	the bu	dlcal		f					
entific ling p	6 25		IF FEMALE:						
ath cer	or us	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	,		23d. Date of delive Month	ery Day Year
. g g	peq	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)				54)
that the deby	detac		Part II. Other significant conditions cor	ntributing to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
requires to been signed	eq p	۵	renal fail	IRE (Chron	10)		1 ☐ Yes 2	. No 3 Prob	pably 4 Uriknown
be w	nous .	ete	Herchhi C				24a. Was an	24h Were auto	psy findings available
he la	age 2	Completed	LIV (+)	•			autopsy performed?	prior to con death?	impletion of cause of
VICAL Iclen: 1 Sertifical	d. Tor	0	25. Was case referred to medical			26. Place of Death (Check only one)	1 ☐ Yes	2□ No
ysici	direc	9	examiner?	lospital:	patient 3 DOA Oth	er: 4 Nursing Home		6 □Other (Specifi	v)
ng Phy ter this	neral		27. Manner of Death 1 ★ Natural 5 ☐ Pending	28a. Date of Injury 28b. T	ime of 28c. Injury	y at 280	d. Describe how inju		·/
Attending or death.	De to	Certification:	2 Accident investigation	(,,		Yes 2 □ No			
r Att	بور	Ĕ	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28	Location (Street ar	nd Number or Rura	J Route Number,
oltal o	De								
DIVISION OF VILAI RECORDS, F.O. DOX of To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours effer death. To the Funerel Director: After this certificate has been signed by the attending	etely fi	edlcal	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the tin Vor investigation, in my o	ne, date and place, and pinion, death occurred	d due to the cause(s at the time, date an) and manner as st d place, and due to	ated. the cause(s)
To th To th	comp	Me	29b. Signature and title of certifier	3 .	29c. Licens	e number	29d. Da	te signed (Month.	Day, Year)
			Jos/10	US4,000.	DZ	12634	14.	4416	2006
	2		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, Print)				
- C-012	0		JUSEPH COS	M. 301 ST 1	PAUL TLAC	E BACT	MARE,	40 212	02
g lag	Stat gistra	- I	31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23a) (A 30 I ST 1 32. Registrar's Signature	- F				
DHMH 17 Re	1.0	#	MAY 1 8 2006	Bearing to Spen	AL.				· · · · · · · · · · · · · · · · · · ·
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			For State Registrar	State of	of Marylar		rtment o			fental Hy	giene,	2006	15	694
	Physici	an	1. Decedent's Name (First, Middle	Last)						2. Date of De	eath Day	Year,	3. Time o	
	Physici /Medic			Elizab		rzberg				MAY	17	2006		P. M.
	Examin	er	4a. Facility Name (If not institution,				•		cation of Death			ounty of Death		
,			Baltimore Wash	ington Me _{6. Sex}	dical C		G1 If Under 1 Yo		Burnie Under 24 Hrs.	O Data of Bi		Anne Ar		
	Funeral Director		216-32-4410	1 ☐ M 2 ☐XF	7. Age (III yis.				lours Min.	8. Date of Bi (Month, Date of Bi	y, Year)		place (State ntry)	
			Usual Residence of Decedent		00	0				AUG 9,	193	rial	ryland	
	how		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation						10d. Inside (·
	Ba-f e	cto		Arundel			Glen E		ie					s 2 X No
	vith th	Dire	10e. Street and Number				10f. Zip Coo				10g. Citize	on of What Cou	ntry?	
	death with the Marylan ime 23a or 28a-f ehow ir must be notified at	Funeral Director	124 Crest Aver		edent Ever in U	I S 12 V		2106]		acity Vac or N	11/	USA I. Race - Americ	can Indian	
2	ter dea	Ē	11. Marital Status 1 □ Never Married 2 Marrie	Armed F	orces?	7.3. 13. ¥	Yes, specify (Cuban, N	inic Origin? (Sp Mexican, Puerto	Rican, etc.)		Black, White,		
8 <i>ū</i> .	or or	þ	3 Widowed 4 Divorced	If Yes, G Year or [ive	1	∏Yes 2DX	No S	Specify:		3	Specify: Wh	ite	
200	within 72 hours after death with the Maryland ene.	Completed	15. Decedent' (Specify only highest	s Education)	16a. Deced	lent's Usual Ockind of work do	ccupation	n na most of work	ina	16b. Kind	d of Business/In	idustry	
0ER	Athin ne. hen	mpl.	Elementary/Secondary (0-12)	1	(1-4or 5+)			etired)	ng most of work			ernatio	na1	
-1 64	D 0		17. Father's Name (First, Middle, L	201)		Clei	cical	18	. Mother's Nam	a (First Middle	Pap			
WWAZ (ould be file Mental Hyg arkad oths atic event,	Be C	William Eitz					10.		len Ott		omanio,		
2 5	2 should and Men ie merks eurmatic	မှ	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Str	reet and				Town, State, Zip	Code)	
Z S	D = 1 = 1		Oscar Wurzberge	er/Husban	ıd	124 (Crest A	venu	ıe Gler	Burni	e. MD	21061		
子 5	of Heall		20a. Method of Disposition	2	20b. I	Place of Dispos				Date		ation - City or To	own, State	
₹ Ë	Pages ment of h ant: If its ury or o		Burial 2 Decremation 3 Removal from State Donation 5 Other (Specify) Metro Crematory, Inc. 5/18/06 Baltimore,											
RATH	permit. Pages Department of important: If it eny injury or once.													
	<u>0</u> 0.5 € 0			regorchi								, MD 21.		
			23a. Part1. Enter the disease of shock, or heart failure. List of	omplications that only one cause on	each line.		1 .						Approxima Interval Be Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a me	25/20		algno	not	-mela	mon	A.			
	Examiner			Due to	(or as'a consec	quence of):								
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(Tansit	Examiner	that initiated events	c										
,	ita be executed ysician and ne burial-transit		resulting in death) Last	Due to	(or as a consec	quence of):								
8760.	- # × @	dicai		d										
89 x	entific ding p	/Me	IF FEMALE:	23c If yes or	utcome of pregn	anov								
Вох	atten for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Feta	al death 3 🗌	Ectopic pregna				23	d. Date of delive Month		Year
P.O.	the d	ıysi	1 □ Yes 2 X No 9 □ Unknown	9□ Unkr			(4,000)							
	s that ned to e deta	by Pi	Part II. Other significant condition	ns contributing to o	death but not res	sulting in the un	derlying cause	e given ir	n Part I.	23e. Did	obacco us	contribute to t	he cause of	death?
g	equire en sig ould b									10	Yes	No 3 ☐ Prob	oably 4]Unknown
5	law re as be 2 sh	Completed	A II							24a. Was		24b. Were auto	psy findings	available
<u> </u>	Tha ate h page	Com								perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	_	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Literation	/		1		. Place of Deat	h (Check only	one)			
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	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	edical (29a. Certifier Cartifying (Check only one) Cartifying	Physician: To the xaminar: On the l	basis of examina	owledge, death ation and/or inv	occurred at th	ne time, o	date and place, on, death occur	and due to the red at the time,	cause(s) a date and p	nd manner as s lace, and due to	tated. o the cause((s)
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	0		30. Name and address of person v	who completed cau	ise of death (Ite	m 23a) (Type, I	Print) \	10			1	/_	- 40	
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		í	For State Registrar		State of	f Marylai	•		ent of H		ind M	lental	, 0	ne 2006	15695
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10	7		30. Name and address of p	erson who c	ompleted caus	of death (Ite	m 23a) (Type							.,	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suni tha Bhogai: Wi 122: A East TOPPA ROOD, Sceek 230 TOWSON HIDU 286 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 8 2006		To t To t		29b. Signature and title of certifie	22			-				-1		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) a M **Physician** /Medical ISSAC R. WHITE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner altimore If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** 10XM 2□ F 20 46 1959 Director 191-52-0169 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ?? is marked other then "naturel", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be nutified at BALTIMORE 1XXYes 2 No MD N/A Director the 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 21218 11 W. 20TH STREET APT. 7N Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other traumatic event. College (1-4or 5+) Elementary/Secondary (0-12) LABORER VARIOUS JOBS 7TH N/A 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be WHITERSPOON INEZ WHITE **ISAAC** 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
111 PARK AVENUE BALTIMORE, MD 21201 19a. Informant's Name/Relationship (Type, Print) 111 PARK AVENUE BALTIMORE, MD CHRIS HOUSE MENTAL HEALTH WORKER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/18/2006 BALTIMORE MD MT. CARMEL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 10 aug lon NORTH AVENUE BALTIMORE, MD 21202 1101 E. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in Jeath) Last Due to (or as a consequence of): Examine physicien end the burial-transit death certificate be execut Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ To the Hospitei Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) NWACATU KNU, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10e, 18, 19a, b per fh 2855, 5-20-06vt
State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Williams Month Day **Physician** グラP M 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**∑**M 2□F Days Hours Min. Yrs. **Director** N/A 05 04 06 MĎ Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show 10d. Inside City Limits 1 XYes 2 No Director MD NA Baltimore 5125 Greenwich Ave 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status event, the Medical Examiner Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. N/A N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Sumame)
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Williams 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental I ent: It item 27 ie marked of ٩ Anthony Williams Sr. item 27 ie marke other traumatic 5125 Streenwich Ave, Baltimore, Md 2. 19a Informant's Name/Relationship (Type, Print) 21229 Willicia Williams-Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Department of H Importent: It its any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 5/15/06 Baltimore, Md 21 natural Fineral Service Licer 22. Name and Address of Facility
March F/H West once. 4300 Wabash Ave, Baltimore, Md 21215 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final di ease or condition Memorrhage Physician esulting in death) /Medical Due to (or as a consequence of). Examiner Syndrome NOCTON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a o and Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be 2 No 3 Probably 4 □Unknown Completed 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1∐ Yes 1 ☐ Yes 2 ☐ No 2 **7** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 npatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Adora Wanedi, M.D. D0061078 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Addra Wondi, M.D.; 30t St. Paul Street Bultimore, MD

31. Date filed (MMA Pay Year 2006)

32. Date filed (MMA Pay Year 2006)

State Registrar

06-03118 Da

-03118			Please Ty	pe or	Print in B	lack Ind	elible Ink				
ale Lyle Ward		Sta	te of Maryland	/ Depa	artment of	Health ar	nd Mental I	Hygiene			
		1- For State	•		rtificate of					200	6 1550
Dhuaiai		Registrar 1. Decedent's Name (First, Middle,	Last\					2. Date of Dea	eg. No	· · · · · · · · ·	U IUU-
Physicia edical Exami								Month	Day	Year	3. Time of Death
euicai Exaiiii	Hei	Dale Lyle War						May 8, 20			1725 hrs
		4a. Facility Name (if not institution,	give street and number))	41	-	or Location of Dea	ath		c. County of Death	
		8429 Lockwood Road				Pasadena			- 14	Anne Arundel	
Funeral		5. Social Security Number 6	Sex 7. Ag	je (In yrs. I	ast birthday)	If Under 1 Ye	ar If Under 24h	rs. 8. Date of Bir	rth(MM	I/DD/YYYY) 9. Birt	hplace (State or
Director			4 D 14 A D E			Months Da	ys Hours N	lin.		Foreig	n
			1 X M 2 F	47	Yrs.			Oct. 2	21,	1958	untry Maryland
*		Usual Residence of Decedent 10a State 10b, County		40- 00	+						
a au		10a State 10b. County		Tuc. City,	Town or Locatio	n					10d Inside City Limits
sho sho	5	Maryland Anne A	rundel	Pa	asadena						1 Yes 2 X No
aryla	Director	10e. Street and Number				10f. Zip Code		1	Og Cit	tizen of What Cour	ntry?
or 2	Ë	0400 - 1 1	. 7		ľ	01100				_	•
r death with the Maryland or items 23a or 28a-f show any must be notified at once.		8429 Lockwood R				21122				ed State	
h wi	Funeral	11. Marital Status 1 Never Married 2 - Marr	12. Was Decedent				lispanic Origin? (an, Mexican, Puei	Specify Yes or No)	14. Race - Ameri White, etc.	can Indian, Black,
deal or it	'n	1 Never Married 2 Marr	lieu [x No		., .,		tio riioani, oto.,		VVIIILE, GLG.	
after al",	by F	3 Widowed 4 Divor	ced If Yes, Give Year		1 🔲 🕥	res 2 X N	o specify:			Specify: Wi	nite
2 hours after "natural", Examiner	D.	15. Decedent's Education (Specif	y only highest grade con	npleted)	16a. Decedent's	Usual Occup	ation (Give kind o	of work done	16b.	Kind of Business/I	
2 ho	ţ	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mos	st of working lif	e. DO NOT use r	etired)	1		
36 Ihan dica	ğ	12		,	Go 0						
S the grant of	Completed	12 17. Father's Name (First, Middle, L	201)		Co-Own	er	Tao santa da san	(El., 1.6.1.)		tomotive	
He do the								me (First, Middle, I		,	
12, ental	Be	Lawrence S. W					Lilly	D. Towns	end	l	
Oould Mad Mic e	ဥ	19a Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre	eet and Number of	or Rural Route Nun	nber, C	City or Town, State	Zip Code)
Baltimore, MD 21215-0036 germit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene Important nof Fleath and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Patricia Ward /	Wife		8429 I	ockwood	d Rd. P	asadena,	MD	21122	
and and lealt lealt litem		20a Method of Disposition			Place of Dispositi			Date		Location - City or	Town, State
or of I		1 A Burial 2 X Cremation	3 Removal from St	ate (crematory or othe	r place)	Mar	y 10,			
im Pag nent fant: or o		4 Donation 5 Other Spe		Met	ro Crema	atory	1	2006	Ca	tonsvill	e. MD
ary parts		21. o of Fune all ervice i	censee		22. Na	me and Addres	ss of Facility				
a 52 7 15		Jun alon	(K1	rkley-	Ruddick	Funeral	Hom	e, P.A.	MD 21061
Physician		23a. I. Enter the disease, or co	omplications that caused	the death.	. Do not enter the	mode of dying	g, such as cardia	or respiratory arm	est, sh	Burnie,	Approximate Interval
/Medical		failure. List only one cause or	n each line.								Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a Amitriityl			intoxica	ation				Death
)		or condition resulting in death)	Due to (or as a conse	equence o	f):						
	L	Sequentially list conditions,	b								
	ne	if any, leading to immediate cause Enter Underlying Cause	Due to (or as a conse	equence o	f):						
	Ē	(Disease or injury that initiated	C		6).						
is er	Examiner	events resulting in death) Last	Due to (or as a conse	equence o	1):						
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oe ex ician	dical	X UNPENDED	_ AMENDED ite	m#23a,	2/,28a-i, _I	penyle, got	05,5/24/06	TT			
P.O. Box 68760, ss that the death certificate be gred by the attending physic detached for use as the bur	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of preg	nancy				23	d Date of delivery	L
387 rtiffi ing as t	an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Feta	death 3	Ectopic preg	nancy		Month D	ay Year
th ce	Ö		4 Pregnant at	time of de	ath 5 Othe	er (Specify)					
Bo deal	λ	1 Yes 2 No 9 Unkni	own 9 Unknown								
that the cred by the detached		Part II. Other significant conditio	ns contributing to deat	h but not re	esulting in the un	derlying cause	given in Part I.	23e. Did to	bacco	use contribute to t	he cause of death?
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	þ							1 Yes	3 2	No 3 Prob	ably 4 🗸 Unknown
	Completed		-			·		245 14/2			
w re	ole	·						24a. Was autop			opsy findings available ompletion of cause of
ec ne la te hi	Ē								rmed?	death?	
F. Hara		25. Was case referred to medical				00 PI-	or of Doroth (Observe	1 ✓ Yes	2N	√ 1 ✓ Ye	s 2 No
Cert Cian	Be	examiner?	Hospital:				of Death (Chec				
al di ihi	٥	1 Yes 2 No	T Impatie		ER/Outpatient		Other Nurs	sing Home 5	Reside	ence 6 🗸 Other	Scene
J of Jing Ph	Ë	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ury (ear)	28b. Time of Inj	ury 28c. Inj	ury at Work?	28d. Describe l	how inj	ury occurred	
	Certification:	1 Natural 5 Pendin	9 Fnd 5/8/		Fnd 5:16	PM 1	Yes 2X No	unk			
Division pital or Attentions after death	<u>2</u>	2 Accident Investi	280 Place of In		ome, farm, street,		building etc	28f Location (5	Street :	and Number or Rur	al Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	Ē	3 Suicide 6 X Could	not be		residence	* * * * * * * * * * * * * * * * * * * *		Passadona	tate 8	429 Lockwoo	nd Road
El G Pi	ပိ	4 Homicide		_		_					
e He e Fu	g	(Check only Certifying Phy	sician: To the best of m	y knowled	ge, death occurre	ed at the time, o	date and place, a	nd due to the caus	se(s) ar	nd manner as start	ed
Division To the Hospital or Attent within 24 hours after death To the Funeral Directors completely filled in by the	Medical	one) 2 Medical Exam	iner: On the basis of exa and manner stated	mination a	nd/or investigation	n, in my opinio	n, death occurred	d at the time, date	and pla	ace, and due to the	cause(s)
F × F ŏ	Z	29b, Signature and title of certifier	Stated			29c. Licen	se number		29d	Date signed (Mon	th, Day, Year)
		him hi				0.0	.M.E.			y 9, 2006	
									IVIA	, 2, 2000	
0		30. Name and address of person w			<i>'</i>						
			t Medical Examine	r 111	Penn Street	, Baltimore,	, MD 21201				
S	tate	31. Date filed (Month, Pay, Year)	Registra	ır's Signatu	re Ana M	8					
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DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

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WELTMAN

		-	For State Registrar	State of	Marylan		artmen rtificat			and Me	ental Hyg	giene Reg. No	006	157	0
	Physici	an	Decedent's Name (First, Middle,		tdan	116					2. Date of Dea Month	Day	Year	3. Time of 5:15	Death P M
	/Medic	al	Robert 4a. Facility Name (If not institution,			/1>	4b. City,	Town, or	Location o	of Death	05	13 4c. 0	06 ounty of Death		
		.05	Anne Arundel Me				Millodae		nnapo				ne Aru		
e Geo	Funeral Director		110 30 3132	6. Sex 7	60	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birtl (Month, Day 12–19–	1945	9. Birth Con Ma:	place (State o intry) ryland	r Foreign
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation			.				10d. Inside Ci	
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-1 ahow ta Mudical Examiner Linet be notified at	ctor	Maryland Anne A	rundel	F	Riva								1 🗆 Yes	2 2 No
	with th	by Funeral Director	10e. Street and Number				10f. Zip		^			-	en of What Cou JSA	intry?	
	death	nera	555 Poplar Driv 11. Marital Status	12. Was Deced		l.S. 13.		2114		gin? (Spec	cify Yes or No- Rican, etc.)		I. Race - Amer		
36	s after , or ite	y Fu	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes 2	. (XNo		1 ☐ Yes		Specify:	, ruento r	noan, ec.,		Black, White ipecify:	White	
215-0036	2 hour		15. Decedent		es. 	16a. Dece	dent's Usua	al Occup	ation			16b. Kind	d of Business/li	ndustry	
1218	vithin 7 ne. han "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4	lor 5+)		kind of wor DO NOT us				ig	3 ,			
d 21	Hygier Hygier other ti	e Col	17. Father's Name (First, Middle, L	2 years		Voc	cation	nal '			(First, Middle,		motive umame)		
/lan	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Ma	To Be	Robert L. A	dams, Sr.					Ca	arol	Perry				
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan cartment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23a or 28s-f show injury or other traumatic event, the Medical Expointer must be notified at a.		19a. Informant's Name/Relationsh Brenda C. Adams								Route Numbe		Town, State, Zi	ip Code)	
ore,	ss 1 an of Heal item 2 rother		20a. Method of Disposition			Place of Dispo	osition (Nan	ne of	e)	Da	. MD 21	20c. Loca	ation - City or,T		
Baltimore,	ment of tank if tank if		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	Cer	r Lady metery					/2006				
Bal	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is eny injury or other tra <u>once.</u>		21. Signature of Furt and Service L	icensee							orge P. nd Rd. I				
760,	/Medical Examiner thysicien and the buriat-transit	Ilcai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Medax Due to (o b		quence of):	DEAMO	ino	ma,	unle	known	prir	nary	Interval Bett	
P.O. Box 68	death certific e attending p id for use as i	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of d	al déath 3[Ectopic pr					23	d. Date of delik		⁄ear
	w requires that the de- been signed by the a should be detached f	ed by PI	Part II. Other significant condition	ns contributing to dea	ith but not res	sulting in the u	nderlying c	ause giv	en in Part I.				e contribute to	1/	leath? Inknown
Il Records,	The law ate has by page 2 st	Completed									24a. Was autop perfor	sv	24b. Were aut prior to codeath?	opsy findings ompletion of c 2 No	available ause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Cth	25		(Check only or				
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	tion: To	1 Yes 2 V No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of (Month		28b. Time of Injury		8c. Injun Wor	4 🗀 140	2	ne 5 🗌 Resid 8d. Describe h			ify)	
Divisi	il or Atter after dea i Director d in by the	Certification:	3 Suicide 6 Could n 4 Homicide determin	200. Place C	of Injury - At hi g, etc. <i>(Specil</i>	ome, farm, st	reet, factory	, office		2	8f. Location (S City or Tow	Street and n, State)	Number or Rui	ral Route Num	ber,
	ne Hospita 124 hours ne Funere letely filler	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the becaminer: On the base and manner	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, a th occurre	nd due to the d	ause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier						e number			29d. Date	signed (Month	, Day, Year)	
	4			mer					591			,	5/14/0	06	
	7		30. Name and address of person w 900 Bestgate Rd				Print) K	(ath	leen 1	kemme	r, M.D.	•			
	Sta Regist	_	31. Date filed (Month, Day, Year) MAY 1 8 2006	32. Re	gistrar's Signa	parte	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** SHAWRON ATILINS 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges Hospital Center Cheverly Prince Georges If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year 1970 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 K F 36 Director 578-82-7671 February 6, Washington, D.C. Usual Residence of Deceden the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exertities is used by notified at 1X Yes 2 □ No Director District of Columbia Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code with 2309 Hartford Street, S.E.; Apt. 2 20020 United States death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercit 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Hairstylist Hair Salon year 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edson Lee **Fullenwilder** Adrian Cordella Leeper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 19a. Informant's Name/Relationship (Type, Print) Kenneth Justin Atkins (Husband) 2309 Hartford Street, S.E.; Apt.2; Washington, D.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 2,2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. Beltsville, Maryland 4 □ Donation 5 Other (Specify) 21 Signature of uneral Service R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician -ECLAMP 5:A /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of tight) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 X Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) _ P.O. the detached April 22, 2006 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined or A 4 T Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifig.

Registrar

State

3001

2. Registrar's Signature

HOSPITAL

30. Name and address of person thro completed cause of death (Item 23a) (Type, Print)

MD

BEXHANE

MAY 0 4 2006

31. Date filed (Month, Day, Year)

			For State Registrar	State of	Maryland		artment rtificate			and M	-	Reg. No.	006	1570)3
	Physici /Medic		1. Decedent's Name (First, Midd Mary L. Ar	ace			41. Cit. T		l anation o	4 Doosh	April	29 2	Year O C	3. Time of Dea	ith M
	Examin	er	4a. Facility Name (If not institution 8713 Contee Rd 5. Social Security Number	. #301	ber) '. Age (In yrs. las	t hirthday)	4b. City, To	re1	If Under 2		8. Date of Birt	Prin	nty of Death	orges	reion
	Funeral Director		578-09-6040 Usual Residence of Decedent	1 M 2 3 F	89	Yrs.		Days	Hours	Min.	(Month, Da 08/25/	y, Year)		olace (State or Fontry)	
	ne Maryland 8a-f ehow	Director		e Georges	10c. City,									10d. Inside City L	
-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Indicate than "natural, or Iteme 23a or 28a-1 ehow other than "natural, or Iteme 23a or 28a-1 ehow event, the Medical Examinar must be multified at	by Funeral	8713 Contee Rd 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Deced Armed For rried 1 Tyes If Yes, Give	2 No tes:	16a. Dece	Was Decede If Yes, specif 1 Yes 2	2070 Int of His by Cubar No	spanic Origin, Mexican Specify:		ocify Yes or No Rican, etc.)	14. I	S.A. Race - Americal Black, White, ecify: white	can Indian, etc.	
21215-0036	ed within 72 rgiene. er than "ne i, the Medic	Completed		est grade completed) College (1-		(Give	kind of work DO NOT use lemake	done d retired)	uring most			Dome	stic		
Maryland	m = 0 5	To Be	17. Father's Name (First, Middle John Petro 19a. Informant's Name/Relation			19h Mailir	na Address (Lu	ıcy I	(First, Middle,)eSanti : I Route Numbe	S		Code)	
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 Is marked any injury or other traumatic ev once.	The state of the s	Ralph Arace—hu 20a. Method of Disposition 12 Burial 2 Cremation 4 Donation 5 Other (21. Signature of Funeral Service)	sband 3 □Removal from S Specify)	20b. Plac	8713 se of Disponetery, crei	Contection (Name matory or other	e Rd of of of place emet	ery (01 La 05/04	aurel, la la la la la la la la la la la la la	MD 207 20c. Location	08 on - City or To	own, State	
8760,	Medical Examiner by physician and physician and physician and sthe burial-transit	dicai Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any 1sacon to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Attached b. Due to (c)		nce of):	ic (ar	diev	456	ulas 1	Hear	t Di	Interval Betwee Onset and Dear	A.San
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Œ	The ate has page	Completed									24a. Was autor perfo 1 \(\text{Yes} \)	osy ermed?	4b. Were auto prior to co death? 1 □ Yes	opsy findings avai impletion of cause 2 \(\text{No} \)	lable e of
Division of Vital	if or Attending Physicien: I after death. Director: After this certifical in by the funeral director, p	Certification: To Be	3 Suicide 6 □ Could	Hospital: 1 In Ir		R/Outpatier 8b. Time o Injury ie, farm, sti	M 28	c. Injury Work	ar: 4 □ Nui	rsing Hor	me 5 Residence 128d. Describe 128d. Location (City or Too	dence 6 how injury oc	curred	fy) al Route Number,	
]	To the Hospitel or Attenwihin 24 hours after deati To the Funerel Director: completely filled in by the	edicai		ing Physician: To the Il Examiner: On the ba and mann	sis of examinatio										
)	To the within to the comp	ĕ	29b. Signature and title of certif	N Al	sto o	0			number	97		,	gned (Month,		
		ate	30. Name and address of perso SALVA JON SO 31. Date filed (Month, Day, Yea	IvesTo, 3		osfi 1	Print)	rin	re	<u>L</u> e	rely,	Ma	nry/	and	
	Regist	rar	mat V 4 2	UUb July	e A	See .									

			For State Registrar	State of Ma	aryland	-	artment tificate				1	Reg. No	21111	5 15	704
	Physicia	an	Decedent's Name (First, Middle, Last)							2	May 1)06 ^{Yea}		of Death AM M
	/Medic	al		ward			4b, City 7	Town or I	Location of	f Doath	May I		. County of De		AIM M
j	Examin	er	4a. Facility Name (If not institution, give s MANOR CARE	treet and number)			Larg		Location of	Death			,	George'	s
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. las	t birthday)	If Under	1 Year	If Under 2		B. Date of Birt	h	9. E	Birthplace (State	
	Director		220-22-7459	M 2 © F 82		Yrs.	Months	Days	Hours	Min.	Month, Da -29-19	23	Ne	lson Ct	y.VA
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c, City.	Town or Lo	cation							10d. Inside	City Limits
	daryis	5	Maryland Prince Geo	orge's			Height	ts							s 2 No
	28e-	Director	10e. Street and Number	,160 0			10f. Zip					10g. Ci	tizen of What	Country?	
	h with		4719 Heath Street	t					207	43				USA	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. do other than "naturel", or iteme 23a or 28e-f ehow event, the Modical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 D N If Yes, Give Year or Dates:			Was Deced f Yes, speci 1 ☐ Yes 2			jin? (Speci , Puerto Ri	fy Yes or No can, etc.)	•	Black, W	nerican Indian, hite, etc. Black	
ည်	72 ho	eted	15. Decedent's Educ (Specify only highest grade			16a. Deced	dent's Usual kind of wor	Occupat	tion	of working	,	16b. K	ind of Busine	ss/industry	
21	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	DO NOT us	e retired)	and the second			_			
72	e filed w Il Hygier other th		07th 17. Father's Name (First, Middle, Last)			H	omemal		18 Mother	r's Name (First, Middle,		rivate		
anc	Mental H Merked of arked of	Be	Elijah Durrett								Thomps		Jumamey		
Z Z	s 1 and 2 should f Heelth and Men item 27 is marke other traumatic	၉	19a. Informant's Name/Relationship (Type	эө, Print)		19b. Mailir	g Address	(Street ar	nd Number	r or Rural I	Route Numbe	er, City	or Town, State	, Zip Code)	
	1 and 2 Heelth a lem 27 is		Linda Thomas/dau	ghter		4719	Heat	h St	. Cap	t.Hgt	s.,Md	. 20	743		
ore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	amoval from State	сеп	netery, cren	sition (Nam	her place		Dat		20c. L	ocation - City	or Town, State	
Ë	Pages ment of ant: if its ury or o		4 □ Donation 5 □ Other (Specify)		Riv		e Parl				06	Riv	erda1e		
Baltimore,	permit. Page Depertment of Important: If any injury or	2 3	21. Signature of Funeral Service License Mary Hedgma	W M013	74	С		Hill	FH I	nc. 4			,Ave.	2074 Suitlan	
			23a. Part 1. Enter the disease, of compli- shock, or heart failure. List only on	cations that caused e cause on each lin	the death. ie.	Do not ent	er the mode	of dying	, such as c	cardiac or i	respiratory ar	rest,		Approxim Interval B Onset and	etween
}	Physician		Immediate Cause (Final disease or condition resulting in death)	Pneumonia									-	On doi: an	
	/Medical Examiner			Due to (or as a		nce of):									
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypertens Oua to (or as a	S10II a.consaqua	nce of):									
	cate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
o,	en an		resulting in death) Last	Due to (or as a	a conseque	nce of):									
8760,	ate be hysici the bu	lical													
.O. Box 6	The law requires that the death centificate be executed to has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	eath 3	Ectopic pre Other (spe						23d. Date of a Month	delivery Day	Year
٥	s that I	by Ph	Part II. Other significant conditions con	tributing to death bu	ut not resulti	ing in the u	nderlying ca	use giver	n in Part I.		23e. Did to	obacco	use contribute	to the cause of	death?
rds	w requires been sign should be	ed b								_	101	res 2	IZNo 3□	Probably 4]Unknown
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œ		Com									perfo	rmed?	death	?	
/ita	cien: ertific	Be	25. Was case referred to medical examiner?	1000							Check only o				
of	Physicien: r this certific ral director,	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	lospital: 1 Inpatier 28a. Date of Injur	nt 2 EF	VOutpatien 8b. Time of		_	4 12 1901		d. Describe h		6 □Other (Si	pecify)	
	ding h. After fune	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м	3c. Injury Work? 1 □ Y	?` es 2 □ N		d. Describer	iow inju	ry occurred		
Division	l or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hom c. (Specify)	e, farm, str	eet, factory,	office		28	f. Location (S City or Tox	Street ar	nd Number or	Rural Route Nu	mber,
	ospital or hours af unerei D ly filled i		00-0-45	<u> </u>											
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	ner: On the basis of and manner sta	examinatio	edge, death n and/or in	vestigation,	in my opi	e, date and inion, deat	h occurred	d due to the i	cause(s date an) and manner d place, and d	as stated. ue to the cause	(s)
	To the Ho within 24 - To the Fu completel	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	te signed (Mo	nth, Day, Year)	
	- > - 0		, h. con	22	l li	MD		D006	2116			(5-03-2	006	
0	(2)		30. Name and address of person who co				Print)	-							
1	0		Meklit Workned,					ve	Greer	nbelt	, Mary	lanc	20776) 	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 4 2006	2. Registra	ar's Signatu	free	W								

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registra Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2006 1258 Brant May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country)
March 28,1925 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days 1X M 2□ F Yrs. 219-14-8863 81 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show 27 is marked other than "natural", or iteme 23a or 28a-f eho traumatic event, the Medical Era: it at must be notified at 1 ☐ Yes 2X No Directo Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any nitury or other traumate. 21740 U.S.A. 16400 National Pike by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. XYes 2 □ No 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: f Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Police Officer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lulu Downs William Roy Brant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16400 National Pike, Hagerstown, MD Helga J. Brant/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/16/2006 Hagerstown, MD Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licenses S.Man 20 1601 Pennsylvania Ave., Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compleshock, or heart lailure. List only o ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, also neach line. Immediate Cause (Final MERINASEN cuta Physician disease or condition resulting in death) /Medical (or as a consequence of **Examiner** lunonta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and use as the buriel-transit that initiated events resulting in death) Last P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been signed page 2 should be Kenchor 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performs 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medicai Certification; To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 29a. Certifie 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ÷ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21740 CORPECIES 1124 Opal Cowl · MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 8 2006 Registrar

		1 - For Stata Ragistrar	State of Maryla		artment o			iene	006	15706
Physic		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		Year	3. Time of Death
/Medi		Milton Beyer			1		May	02,	2006	12:04 p ^M
Exami	ner	4a. Facility Name (If not institution, give s	reet and number)		Rocky	n, or Location of Deat	.n		ontgome	
Francis		Hebrew Home 5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Y	ear If Under 24 Hrs	8. Date of Birth		Q Rint	hplace (State or Foreign untry)
Funeral Director		066-10-8086	M 2□F	88 Yrs.	Months Da	ays Hours Min.	Sept. 2	8,19	17 Nev	y York
pu »		Usual Residence of Decedeni 10a. State 10b. County	100	City, Town or Le	ocation					10d. Inside City Limits
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the N 28a-f	Director	Maryland Montgomer 10e. Sireet and Number	У	KOCKVII	10f. Zip Co	de	1	l0g. Citize	n of What Co	untry?
IZIS-LOUGO within 72 hours after death with the Maryland ane then "naturel", or Items 23a or 28a-f show the Madical Examirer mest be notified at	D	6121 Montrose Roa	ıd		2085	52		Unit	ted Sta	ates
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3-0030 72 hours af naturel; or dical Exam	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates: WWI		edent's Usual O	ccupation	1	16h Kind	Wh:	
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Viano outd be file Mental Hi arked oth	10	Max Beyer				Rose	Unger	===		
Baltimore, Maryland ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Importent: if item 27 is marked other then "naturel", or items 23a or 28a-f show any injuly or other traumatic event, the Marical Examinating the notified at gonge.		19a. Informant's Name/Relationship (Type			-	reet and Number or R				
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it. P. sartme ortent		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License				ddress of Facility Tibute Fur				
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Records, he law requires t e has been signe age 2 should be o	Completed						24a. Was a			itopsy findings available
The lav	dmc						autop perfor 1 Tyes	med?	prior to death?	completion of cause of
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of Vital Physicien: r this certifica	To B	examiner? 1 ☐ Yes 2 🖾 No	lospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatie		A STATE OF THE PARTY OF THE PAR	Home 5 ☐ Resid	ence 6	Other (Spe	cify)
on of		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Dale of Injury (Month, Day Year	r) 28b. Time Injury		Injury at Work?	28d. Describe h	ow injury	occurred	
Vision Attending at death. ector: Aftel by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	One Blace of Injury)t home form o	M troot factory of	1 ☐ Yes 2 ☐ No	28f Location (S	Street and	Number or Ri	ural Route Number,
Division of Vital or attached to a standing Physicien:] after death. Director: After this certification by the funeral director, p	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp		itteet, factory, of	IIIC8	City or Tow		rambor or ric	arar riodio reambor,
Division To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		sician: To the best of my ner: On the basis of exam and manner stated.							
o the rithin (o the omple	Med	29b. Signature and title of certifier	and the second		29c. L	icense number		29d. Date	signed (Mont	h, Day, Year)
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3+1		30. Name and address of person who co		Item 23a) (Type				3,2	-, 2000	
		Andrew Kundrat,			ose Roa	ıd; Rockvil	lle, Mary	1and	20852	
S Regis	tate	31. Date filed (Month, Day, Year)	32. Pogislrar's S	ignature	Locate					

			For Stete Registrar	State of Maryla		artment of H			giene	6 15707
	° Physicia /Medic		1. Decedent's Name (First, Middle,	Last)	13	Bahue	outis	2. Date of Dea Month May	ath	3. Time of Death
	Examin Funeral Director		4a. Facility Name (If not institution, The Johns Ho 5. Social Security Number 055-44-4749	okins Hospi	yrs. last birthday) Yrs.	4b. City, Town, or Balf If Under 1 Year Months Days	MORC If Under 24 H	City	4c. County of D	Birthplace (State or Foreign Country)
	σ	or	Usual Residence of Decedent 10a. State 10b. County VA Arling		City, Town or Lo					10d. Inside City Limits 1√□ Yes 2 □ No
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. If eath and Mental Hygiene. Itiem 27 is marked other than "neturel", or items 23a or 28a-f show other traumatic event, the Medical Evandrancing Let notified at	d by Funeral Director	10e. Street and Number 1505A Colonial 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Terrace 12. Was Decedent Ever in Armed Forces? 1	in U.S. 13.	10f. Zip Code 22209 Was Decedent of Hif Yes, specify Cubar 1 Yes 2 No	Specify:	(Specify Yes or No ento Rican, etc.)	Specify:	American Indian, White, etc. White
21215-0036	ed within 72 h /giene. er than "netu f, the Medica	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired, emaker	during most of t		Own Home	ŕ
ryland	should be filed and Mental Hygi is marked other aumatic event,	To Be	17. Father's Name (First, Middle, L Alexandros Alex 19a. Informant's Name/Relationshi	andridou	19b. Mailir	ng Address (Street a	Chryso	Name (First, Middle, 0ula Stavi r Rural Route Numbe		te, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is eny injury og other trau		Dimitrios BalaE 20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (Sp	20 3 □Removal from State	b. Place of Dispo cemetery, crei		θ)	ace, Arlin Date 9-2006	20c. Location · Cit Athens, (y or Town, State
Balt	permit. Departr Import. eny ini		21. Signature of Funeral Service L	of Friday		130 Wisco	nsin Av		ashington	DC 20016 Approximate
8760,	cate be executed / Medical Examiner Medical Examiner Stree burial-transit Street Medical ical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a conduct of the co	nsequence of):	l Heini Vienny				Interval Batwaen Onset and Death 3 recording 67 Geases	
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<u>a</u>	ires that signed b	by	Part II. Other significant condition	s contributing to death but not	t resulting in the u	nderlying cause give	en in Part I.	23e. Did to	2.2	te to the cause of death? Probably 4 Unknown
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)	vith To To con		30. Name and address of person v	200 MD	(Item 23a) (Type	200	6368	2 1	MAY 1,	2004
	St	ate	Methow Co	enis 600 h	1. WOLF	e St. B	Altimo	ace, MAR	Yland ?	21287
	Regist		MAY 04	2006 Regue	St. 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #20c & State of Maryland / Department of Health and Mental Hygiene #20b, per f.home, 5/5/06, Certificate of Death WCHD, E.T Reg. No. Amended item 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 2006 12:55 A M Cora Louise Barrett /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 12 Village Way Ocean Pines Worcester II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Dec. 29, 1 Birthplace (State or Foreign Country)
 Indiana 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2⊠F Months Days Yrs. 64 315-44-1647 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a' Hygiene. I other then "neturel", or Iteme 23a or 28a-f ehow went, the Medical Examiner must be nutified at 1 ☐ Yes 2 ☑ No Directo Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Village Way 21811 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. The marked other then "neturel", or Iteme 23, and 17 to other treumatic event, it a Medical Experimentury or other treumatic event, it a Medical Experiment mun. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No II Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roger J. Kramer Ruth M. Lovett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Village Way, Ocean Pines, Md. 21811 Maurice Barrett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Jown, State Woodruff, Memorial Park 5-8-06 Canonsburg, FA Lawy Gordens The Burbage Funeral Home 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) 108 William St., Berlin, Md. 21811 23a. Part1. Enter the disease, or complications that caused the clean. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatie Corcinoma of **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) sete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes ※XXNo 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes XXNo this After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury 1XXNaturat 5 Pending s effer de... al Director: After to the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I tour P. f D0014314 5/3/2006

State Registrar

DHMH 17 Rev 1/2001

MAY 0 5 2008

31. Date liled (Month, Day, Year)

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANPITP KLUG. 145E CONOIL STRUIT Solis Sury, MD. 21801

			1 - For State Registrar	State of Maryland	-	rtment of H			giene 2 ()	06	15709
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	Year	3. Time of Death
	Physici: /Medic		Kenneth 0.	Butler				April	27, 200		11:00a ^M
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Deatl		4c. County		
			Malcolm Grow Hos	pital		Camp Sp			Prin	ce Ge	orges
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti	h v. Year)	9. Birthp Coun	lace (State or Foreign
	Director		263-40-2089	73	Yrs.			Feb. 1,		Key	West, Fl.
3	A		Usual Residence of Decedent 10a. State 10b. County	10c, City	, Town or Loc	cation				1	0d. Inside City Limits
1	t eho	ō	Manual and Dudus as Co								1 Yes 2 □ No
1	28a-	ect	Maryland Prince Ge	orges Up	per Ma	10f. Zip Code			10g. Citizen of V	What Coun	try?
1	Sa or	0	9706 Cedar Hollow	I.n.		20774	1		United	Stat	95
i i	T8 2	Funeral Director		2. Was Decedent Ever in U.S	S. 13. V	/as Decedent of His Yes, specify Cubar		pecify Yes or No-		e - Americ	an Indian,
0	or Ite		1 ☐ Never Married 2X Married	Armed Forces? 1 X Yes 2 ☐ No				o Rican, etc.)		ck, White,	
3	E P	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2½ No	Specify:		Specify	Blac	k
ה ה	inter within 2 nous are been with the maryane tall Hygien Hygien to other then "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give I	ent's Usual Occupa	luring most of wor	king	16b. Kind of B	usiness/Ind	lustry
7	90 J	np.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired))				
7	tygier ther ti	S	12		U.S	. Army Re		no (Time Adidale	Gover		
	d of	Be	17. Father's Name (First, Middle, Last) Oliver Butler					ne (First, Middle,		76)	
<u> </u>	d Merk	은	19a. Informant's Name/Relationship (Typ	o Print)	10h Mailio	g Address (Street a		ia Farri		Ctata Ti-	Codol
20 3	th an traul		Theresa Butler /W:		1	Cedar Hol					,
ນ໌ :	Heel tem 2		20a. Method of Disposition	20b. Pt	-	sition (Name of atory or other place		Date	20c. Location -		
	ant of strict if it		1 ⊠Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			atory or other place id Vetera:		/2006	Chelten	ham,	Md.
aitimo	perfilit. Fages I affor a should be filed within 7.5 flouts affer been with the waryfall agranteer of Heelith and Model Hygiene. Important: if frem 2.7 is marked of their then "natural", or frems 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be notified at 80cc.		21. Signature of Funeral Service Liceuse	3	22.	Name and Addres	s of Facility_	-			
ă	E G E G		Kint a. San	10 M VIDES	-	Name and Addres Alexande 5538 Mar	Iboro ^P Pi	e Funera ke/Fores	tville,	Md:	20747
	_		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death							Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	C One an		o Ho	ant	Fort	11.00		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ence of):	e pre	1	100	urc_		
E	xaminer		Sequentially list conditions b.	Doal	se se	2					
7	o #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (ur as a consequ	ence of):						
	and trans	Examin	that initiated events c. resulting in death) Last	D e to or as a consegu	4671	100					
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00/00	physi the l	dicai	d.	-11000	M CA	a.	4.6	77.640		-	
X	ding ding	/Me	IF FEMALE: 23	c. If yes, outcome of pregnar	псу		-		23d Da	te of delive	D/
Ď į	atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ★o	1☐Live birth 2☐Fetal 4☐Pregnant at time of de		Ectopic pregnancy Other (specify)			Mo		Day Year
j	by the	Physician/Me	9 Unknown	9□ Unknown							
records, r.o. box o	ned t	by P	Part II. Other significant conditions cont	ributing to death but not resu	lting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
cords	an sig		Hyperch	westerno	mia			1 🗆 Y	es 2 No	3 Prob	abiy 4 □Unknown
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ř	ate ha	Completed		Y Y				autop perfor 1 Yes	med?	death?	npletion of cause of 2□ No
N I G	ortifica ctor. 1	Be	25. Was case referred to medical examiner?				26. Place of Dea	ith (Check only or			
סו אונש	his ce I dire	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 🗆 E	ER/Outpatient		4 U Nursing H	lome 5 Resid	ence 6 □Oth	er (Specify)
ָב בּי ס	Viter t	ë.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occur	red	
S	attending or death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				/es 2 □ No	004 1 (0			
	after of Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rura	Route Number,
	ours ours neral		29a. Certifier 1X Certifying Physi	cian: To the best of my know	viedge, death	occurred at the tim	e. date and place	and due to the o	ause(s) and ma	inner as st	ated
	To the nospine or Attended in partials. The law requires thethe beath column to the beath column to the Europeus after death. To the Funeral Director: After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Examinone)	er: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my op	inion, death occu	rred at the time, o	date and place,	and due to	the cause(s)
	withir To th	Me	29b. Signature and title of certifier	n 0	/	29c. License	number	i	29d. Date signe	d (Month, L	Dal. Year)
	0		LANDON	Blech	0	10-	3942	1	5/1	10	0
	131		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, I	Print) n/ a	170	0 /)	11,	11
	,		Jones 1	Note!	150	mer	Cart	ke Le	ne of	Hell,	dayo Ma
	Sta Registr		"MAY" 0"4", 2006"	32. Heghtvars Signat	alle .						10714

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 15710

		I- For State Registrar	,	Certific	ate of	Death		, ,	R	eg. No.	UU	0 1 1 1 1
Physicia	ın/	Decedent's Name (First, Middle, L.)	_ast)						Date of Dea Month	Day Year		3. Time of Death 1016 hrs
ledical Examir		Patrick 4a. Facility Name (if not institution,	Ioseph	Curti	1 4	o. City, Town, or	r Location o		May 11, 2	4c. County of	Death	10101115
		Baltimore Washington N	-			Glen Burni				Anne Aru		
Funeral		Social Security Number 6.	Sex 7. Age (In yrs last bir	thday)	If Under 1 Yea			8 Date of Bir	th(MM/DD/YYYY)	9. Birth; Foreign	olace (State or
Director		217-04-5986	1 X M 2 F	38	Yrs.	Months Day	ys Hours	Min.	Sept	.15 , 1967	Cour	ntry)Maryland
>.	ļ	Usual Residence of Decedent 10a. State 10b. County	11/	o City Town	or Locatio	n						Od Inside City Limits
ow any		Maryland Anne Ar	rundel	oc. City, Town	olis	••						1 Yes 2 X No
e Maryland or 28a-f show Ted at once.	cto	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wha		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she marite event, the Medical Examiner must be notified at once	Director	930 Shipmaster	: Court			21401				USA		
with' i		11 Marital Status	12. Was Decedent Ev	ver in U.S.		Decedent of Hi s, specify Cuba				14. Race - White,		an Indian, Black,
or ite	Funeral	1 Never Married 2 Marr	1 Yes 2XX	₹ No		_		, i doito iti	our, oto.)			_
rs afte	ā	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ced If Yes, Give Year or Dates:	eted) 16a		Yes 2 X No		kind of wor	rk done	Specify: V		
2 hou	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+))	during mo	st of working life				Landsca	ning	T
5-0036 iled within 7 Hygiene 1 other than	du	12		L	andsc	aper						
21215-00; uld be filed with Mental Hygiene marked other it c event, the Med		17. Father's Name (First, Middle, La								Maiden Surname)		
D 2121 should be fi and Mental 7 is marked	o Be	John Joseph 19a Informant's Name/Relationship		19	b. Mailing	Address (Stre		alie		CANCES mber, City or Town	Fur State. 2	
and 2 shoul ealth and N tem 27 is n traumatic	۲	Rosalie F. Curti		8.7		•	er Ct	Ar	napol :	is. MD 21	401	
- 정불문론	- 1	20a Method of Disposition	2 Demonstran State		of Disposit	ion (Name of ce	emetery,	May 1	7. 200	20c. Location -	City or To	own, State
MOP Pages ent of mt: Il	'	1 XBurial 2 Cremation 4 Donation 5 Other Spec				eaven C	emete	ry		Silver S	Sprin	ng, MD
Baltimore, permit. Pages I at Department of Hee Important: If ite		21. Signature of Funeral Service Li			22. Na	me and Addres	ss of Facility Kalas	Fune	eral Ho	ome, P.A.		
	-	23a. Part I. Enter the disease, or co	omplications that caused th	e death Doir	1297	3 Salam	ons T	sland	Rd.	Edgewate	er. N	MD 21037 Approximate Interval
Physician /Medical		făilure. List only one cause or	n each line. a. Atherosroscl						- ,	,,	- 19	Between Onset and Death
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760, ficate be g physicia the buria	/Medical	IF FEMALE:	23c. If yes, outcome			0050,0/1	2/00 1.			23d Date of	delivery	
687 ertifica ding p	an/I	23b. Was decedent pregnant in the past 12 months?	T Live birtii			al death 3	Ectopio	c pregnanc	су	Month	Da	y Year
Box 68's death certifithe attending	ysician	1 Yes 2 No 9 Unkn	' -	ne or death	5 Oth	er (Specify)						
n of Vital Records, P.O. Box 68 ding Physician: The law requires that the death certift here this certificate has been signed by the attending frameral director, page 2 should be detached for use as	/ Phy	Part II. Other significant condition	ns contributing to death t	out not resulti	ng in the u	nderlying cause	given in Pa	art I.		obacco use contrib	_	
r, P.O. ires that the signed by I	d by											bly 4 Unknown
cords law requi	ompleted								24a. Was auto	psy pi	rior to co	ppsy findings available mpletion of cause of
Recort The la	Com	_									eath? Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been seled in by the funeral director, page 2 should!	Be (25 Was case referred to medical examiner?	Hospital:		2 4		Other	_	Home 5	Residence 6	Other:	
Physic Physic er this	7	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 🗸 ER/6	Time of Ir		ury at Work			how injury occurre	J	
ion of tending Pheath	ertification:	1 X Natural 5 Pendir		ar)		1	Yes 2	No				
ViSion Atte	ifica	2 Accident Investi 3 Suicide 6 Could	not be 28e. Place of Inju	ry - At home,	farm, stree	t, factory, office	building, et	tc. 2	8f. Location (r or Rura	al Route Number, City
Divi	Cert	4 Homicide determ	(0)00.77									
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Phy one) 2 Medical Exam	ysician: To the best of my l niner:On the basis of exami	knowledge, d ination and/or	eath occuri	red at the time, on, in my opinion	date and pla on, death oc	ace, and d ccurred at t	ue to the cau the time, date	se(s) and manner and place, and du	as starte ue to the	d. cause(s)
To t with To t	Medical	29b. Signature and title of certifier	and manner stated				nse number			29d Date signe		
ا م		1/1/	176-01		1	0.0	M.E.			May 12, 20	06	
5		30. Name and address of person w								1		
			Assistant Medical Ex		111 Pe	nn Street, B	altimore,	MD 21:	201			
S Regis	tate trar	31 Date filed (Month, Day, Year)	32. Registrar's	s Signature	Ka	P. F						
DHMH 17 Rev 1/2			J. S. Commercial Comme	0	RIGINAI	9						

		1 - For State Registrar	State of Mar	yland / Depa		lealth and M	Mental Hyg		006	15711
Physici	an	Decedent's Name (First, Middle, La. Jean Ann Chand					2. Date of Dea Month May	Day 9	2006	3. Time of Death 8:55 A M
/Medic Examin		4a. Facility Name (If not institution, given	e street and number)	-	4b. City, Town, or Rockvill	r Location of Death		4c. Cou	nty of Death	
Funeral Director		204-14-5424	ex	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan. 3]	, 192	9. Birthp Cour Read	lace (State or Foreign ltry) ing, PA.
the Maryland 28s-f show	rector	Usual Residence of Decedent 10a. State 10b. County Maryland St. Mar 10e. Street and Number		Oc. City, Town or Lo	totation 10f. Zip Code			10g. Citizen	of What Cour	0d. Inside City Limits 1 ☐ Yes 2 📉 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Heelth and Mental Hygiene. Disportment: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Funeral Director	48625 Fox Harbo 11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	r Rd. 12. Was Decedent Ev Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		20680 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto		Unit	ed Sta Race - Americ Black, White,	tes an Indian,
Baltimore, Maryland 21215-0036 semit. Pages I and 2 should be filed within 72 hours alt Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other then "natural", or any injury or other traumatic event, the Madical Exambance.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	dent's Usual Occup kind of work done DO NOT use retired emaker	d) 		Own	Business/Ind	dustry
yland rould be file Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last, Robert Gaul				18. Mother's Nam	Reedy			
e, Mar 1 and 2 st Heelth and em 27 is n ther traun		19a. Informant's Name/Relationship (Carol L. Dietzel 20a. Method of Disposition	** *	13806	Longacre sition (Name of	es Preser		otoma		20854
Baltimor permit. Pages Depertment of i Important: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service Licer	y)	сетеtеry, crei Brinsfiel	matory or other place	Cre 5-1	3-2006	Charle	otte Ha	all, MD.
		Kyle S. Simo 23a. Part1. Enter the disease, or com shock, or heart failure. List only tmmediate Cause (Final	plications that caused th	e death. Do not ent	2955 Ho11 er the mode of dyin				Maryla	Approximate Interval Between Onset and Death
Physician /Medical Examiner per support of the pringle franch white pringle franch with the pringle franch franch with the pringle franch fran	dical Examiner	disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Acute R Due to (or as a control of the control o	ive Heart consequence of): enal Fail consequence of): lastic Sy consequence of):	ure					
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O 15 2 15	þ	Part II. Other significant conditions of	contributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to			ne cause of death?
Vital Reco ician: The law re certificete hes be ector, page 2 sho	Completed						24a. Was a autope perfor 1 Yes	sy med? 2 X No	b. Were autoportor to condeath?	psy findings available inpletion of cause of 2 No
Sion of tending Physicath. tor: After this the funeral dir	Certification: To Be	25. Was case referred to medical examiner? 1 Yes	e 200 Diagonia	/ear) 28b. Time o Injury	f 28c. Injun Wor M 1	4 Li Nursing no	ome 5 Resid	ence 6 2 0	curred	Hospice
DIVI To the Hospital or At within 24 hours efter or At To the Funerel Direct completely filled in by	edical Cer	29a. Certifier 1X Certifying Ph	sysician: To the best of entire: On the basis of entire:	my knowledge, deat	h occurred at the tin	ne, date and place,	and due to the c	ause(s) and	manner as st	ated.
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner state	^ ∑	29c. Licens	e number		29d. Date sig	ned (Month, 1	Day, Year)
Sm		30. Name and address of p on who Joseph Kaplan	completed cause of dea 6001 Muncas			e MD. 208	355			
Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar		4					

			1 State	artment of Health and Mertificate of Death	, ,	0000	15710
			Registrar 1. Decedent's Name (First, Middle, Last)	runcate of Death	Reg. 2. Date of Death	No.	3. Time of Death
	Physici	an	Yolande G. Cunliffe		Month	Day Year	М
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	April 30,	4c. County of Deal	1:50 P "
	Examin	er	Casey House	Rockville		Montgomer	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
	Director		106-16-9084 1□ M 2Å F 87 Yrs.	Months Days Hours Min.	(Month, Day, Yo Apr 22 19		uintry) 1
	9		Usual Residence of Decedent			19 1000	
	how E	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Ba-f-	5	MD Montgomery North Bet				1 M Yes 2 No
	or a	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Co	untry?
	death with the Maryland ms 23a or 28a-f ehow const be notified at	Funeral	5550 Tuckerman Lane Apt. #156	20852		ited Stat	
	er de	ů,	11. Marital Status 1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - Ame Black, White	
5	irs at	by	3 XWidowed 4 Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	ite
ş	or star	ed	15. Decedent's Education 16a. Dece	edent's Usual Occupation	161	b. Kind of Business/	Industry
<u> </u>	n n	ple	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)	ng		,
2	d with	Completed		Clerical	P	ersonnel	Retail
9	office office vent	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)	
<u> </u>	Ments Ments mrked mrtc e	10	Alexander Gall	Marie Fo	orbes		
Maryland 21215-0036	and le ma			ing Address (Street and Number or Rura			
Σ.	and and n 27		Salle C. Aylor / Daughter	Colonel Lindsay Co		Church, V	'A 22043
ore	E T T T T T T T T T T T T T T T T T T T		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	osition (Name of Dimatory or other place)	ate 200	. Location - City or	Town, State
Ě	Pag ment uny		4 □ Donation 5 □ Other (Specify) National			11s Churc	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If term 27 is marked other then *neturel; or tems 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be inclined at ance. Once.			2. Name and Address of Facility Jose			
	₫ O .5 ĕ Ø	9 97	TO COLO	130 Wis. Ave NW Was			
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
1	hysician	1	Immediate Cause (Final disease or condition resulting in death) Cerebral Vascula	r Accident			Criser and Death
	/Medical Examiner		Due to (or as a consequence of):				
		_	Sequentially list conditions, If any landing to immediate b. Due to for as a consequence of the conditions of the condi				
	red nsit	Examiner	cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transit	xar	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8/60,	ate be executed hysician and the burial-transii	cal	d				
8	g physias the l	70					
ROX	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deli	ivery
	deat	SICI	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5	Other (specify)		Month	Day Year
л О	at the by the stach	å Ä	9 Onknown		T		
ń	res that the de signed by the a be detached t	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	I.I		the cause of death?
0	w require been si should t	ted			T Yes	2 🛣 No 3 🗆 Pri	obably 4 Unknown
Hecords,	law lasb s2st	Completed			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
		ပိ			performed 1 ☐ Yes 2 💢		2∏ No
Vital	nysiclan: Th nis certificete director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
5	Phys this raldii	J.	1 Yes 2X No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	HIL 3 DOA 4 Nursing Hon	ne 5 Residence		Hospice
Division of	ding f	阜	1X Natural 5 Pending (Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	ou. Describe now	injury occurred	
181	of or Attend after death Director: /	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		8f. Location (Stree	t and Number or Ru	ral Route Number.
2	after Dire	Certification:	4 ☐ Homicide determined building, elc. (Specily)		City or Town, S	itate)	
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the caus	e(s) and manner as	stated.
	n 24 n 24 ne Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)
			1/5/~ ~	D35635	Mar	y 01, 200	6
- (2		30. Name and address of per on who completed cause of death (Item 23a) (Type				
			Joseph Kaplan MD 6001 Muncaster Mil	<u></u>	0852		
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 2006 32 Registrar's Signature	ade			
	negisti	Œ!	mitte of Louis Balling San Page				

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:30 A David Lee Carey ,2006 nou /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SALISBURY REHAB & NURSING CENTER WICOMICO SALISBURY, MD. 21804 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2 | F Maryland Director 217-14-8716 June Usual Residence of Decedent the Maryland 1∩a State 10b. County 10c. City. Town or Location 10d. Inside City Limits framework of the fram "nature!" or theme 23s or 28s-f ehow traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Wicomico Fruitland MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 302 Cedar Lane 21826 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑Yes 2 □ No If Yes, Give Year or Dates: 1941–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 X Married Specify: Black 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Worcester County Board 12th Mechanic/Bus Contractor of Education land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be ind Mental and Mental 2 Derotha Justice Joseph Carey Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 permit Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trai once. Ruth C. Carey/Wife 302 Cedar Lane - Fruitland, Maryland 21826 Itimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Ebenezer/Mt. Wesley Church 5/5/2006 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill, MD 22. Name and Address of Facility 21. Signatur of Funeral Service Licensels 1213 Jersey Road - Salisbury, dutta MD. 21801 Jolley Memorial Chapel 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on such line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician goar-4 /Medical Due to (or as a consequence of): Examiner · las Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s nsequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan has this certificate 1□ Yes 2 17 No Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₽No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Hospital 624 hours a within 24 hours a To the Funeral L 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) GED 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA WILLIAM ROBINS, M.D. 200 CIVIC AVE., SALISBURY, MD. 21804 31. Date filed (Month, Day, Year) 32 Registrar's Signature State marci Registrar 2006 04

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Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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		1	For State Registrar	State of Marylar		artment of H rtificate of L			ene2 0 0	6 15714
	sician	1	. Decedent's Name (First, Middle, Last	ey Corkell, I	TT			A Month	27 20	
	edical ıminer	7	a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
Fune Direct	_	5	Social Security Number 6.15e	ital at Eas- 7. Age (in yrs. 56	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y November 6)	(ear) 9.	Birthplace (State or Foreign Country) Manyland
Within 72 hours after death with the Maryland one. Than "natural", or Iteme 23e or 28e-f show	al Director	Director	Jsual Residence of Decedent Oa. State 10b. County Carolin Oe. Street and Number 9634 Bates Road		ty, Town or Lo	10f. Zip Code 21629			g. Citizen of Whal	10d. Inside City Limits 1 □ Yes 2 ℚ No Country? Ites of America
JUSO tours after deal	d by Finneral	2	1. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ 130 ivorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ② No	Specify:		Specify:	merican Indian, /hite, etc. QUCQS LAN
D . D .	Re Complete	ן מ	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1	College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work) driver 18. Mother's Nami	e (First, Middle, Ma	uiden Sumame)	ransportation
d 2 should be file the and Mental Hy	To	0	19a. Informant's Name/Relationship (7	• • • •		ng Address (Street a	and Number or Run		City or Town, Stat	4 4 0 0
ges 1 and 2 tot Health		-	Donis Usilton 20a. Method of Disposition 1 □Burial 2 □Cremation 3 □		Place of Dispo	Wilhelm . Distingtion (Name of matory or other place)		-	y Land 2 Dc. Location - City	7629 or Town, State
permit. Pages 1 a Department of Hea Importent: If Item			4 Donation 5 Other (Specify 2) Ingnature 1 Funeral Service Licen	De	M	emetery 2. Name and Addres Oore Fune 2 South S	5/3/2 ss of Facility ral Home,	P.A.	enton, M	-5
rate be executed hysician and the invision and the horizontal raneit	uer ransır	Xa	disease or condition resulting in death) Sequentials list and one if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of Due to (or a) Due t	quence of):					
law requires that the death certificate be executed as been signed by the attending physician and a consider the trained by the attending physician and the principle of the principle parties.	ISO as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fets 4 Pregnant at time of o	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
uires that			Part II. Other significant conditions co	1 1 1 1			en in Part I.			e to the cause of death? Probably 4 Unknown
The ate h	page z shou	Completed by	medica medica	1 evalue	eti'dr	7		24a. Was an autopsy performe	prior deat	e autopsy findings available to completion of cause of 1? fes 2 \square No
Attending Physicien: The la reference Attention desired the this certificate has been assented to the terminal disperse and a	e funeral director	ation: 10 Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. Injun Worl	er: 4 Nursing Ho	h (Check only one) ome 5 ☐ Residen 28d. Describe how	ce 6 □Other (5	Specify)
el or Attending s after death.	od in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory, office		28f. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,
To the Hospitel or Attending Ph Within 24 hours after death. To the Funerel Director: After th	pletely fills	edical	(Check only 2 Medical Examone)	ysician: To the best of my kn iner: On the basis of examin- and manner stated.		nvestigation, in my o	pinion, death occur	red at the time, date	e and place, and	due to the cause(s)
To the within 2	Eloo	Σ	29b. Signature and title of certifier	Cluca	5 M	29c. Licens	025.	287 (3/2006
			30. Name and address of person who or THOM AS CINICE State filed (Month, Day, Year)	NE 919 Sou	M W	ashiasta	~ St Ea	s kn Mr	2160	(
Re	State gistra	e	31. Date filed (Month, Day, Year)	32. Hegistrar's Sign	ature	acres of				

			State of Mar State of Mar State Amend Item#8 per INF			•	•	15715
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Viola M. Cole		innounce of Doub	2. Date of Death Month April 2	n Day Year	3. Time of Death 3:50am M
	Examir	_	4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home		4b. City, Town, or Location		4c. County of Death Prince Ge	eorges
	Funeral Director		5. Social Security Number 2.0−28−6572 6. Sex 1 M 2 ☑ F 7. Age (n yrs. last birthday) 75 Yrs.	If Under 1 Year If Under Months Days Hours	8. Date of Birth Min. Month, Day, April 25	Yea l 931 9 Birth Col. 1931 Dent	place (State or Foreign intry) csville, Md.
	Maryland s-f ehow	tor		Oc. City, Town or Lo Upper Ma				10d. Inside City Limits 1 → Yes 2 → No
	h with the	al Director	10e. Street and Number 11422 Red Jade Ct.		10f. Zip Code 20774	10	Og. Citizen of What Cou	
936	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel" or Items 23e or 28e-f ehow any Injury or other traumatic event, the Medical Eraciliar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Event Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☐ No Specif		14. Race - Amer Black, White	ican Indian,
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Maryland 21215-0036	uld be filed v Mental Hygie irked other t	To Be Co	12 17. Father's Name (First, Middle, Last) Thomas O. Chesley	Sh		her's Name (First, Middle, M	Private daiden Sumame)	
	l and 2 sho leath and I m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Cynthia Cole / Daughter	11422	Red Jade Ct.	ber or Rural Route Number, Upper Marlbo	oro, Md. 20	774
Baltimore,	mit. Pages bartment of hoortent: If ite injury or of		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lightsee	Maryland	2. Name and Address of Fac	lay 3, 2006 (Cheltenham,	Md.
ö	Dermi Depa Impo eny Ir		23a. Part1. End the disarse, or condications that caused the shock, or heart faillire. List only one cause on each line.			orike/Forest		A 20747 Approximate Interval Between
760,	Physician /Medical Examiner specified by the price of th	cal Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last Metastat Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause) Due to (or as a condition of the cause)	consequence of):	arcinoma of F	rontal Lobe		Onset and Death
Box 68	Attending Physicien: The law requires that the deeth certificate ir death. ector: After this certificete has been signed by the ettending phys by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □Other (specify)		23d. Date of delive	rery Day Year
rds, P.	quires thet (in signed by uld be deta	ed by Ph	Part II. Other significant conditions contributing to death but Seizures	not resulting in the u	nderlying cause given in Par		acco use contribute to	
Reco	The law requir ste has been si page 2 should	complet	Altered Mental Status Renal Insufficiency			24a. Was an autopsy perform 1 ☐ Yes 2	prior to co	opsy findings available ompletion of cause of
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funsral Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No Hospital: 1 □ Inpatient 27. Manner of Death 28a. Date of Injury.	28b. Time o	nt 3□ DOA Other: 4□	ce of Death Check only one Nursing Home 5 Resider 28d. Describe how	nce 6 Other (Speci	fy)
ivision	i or Attending efter death. Director: Afte in by the fun	Certification;	1 Anatural 5 Pending (Month, Day Y 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc.	- At home, farm, st	M 1 ☐ Yes 2 [eet and Number or Run State)	al Route Number,
J	Hospital 24 hours e Funsral C letely filled	Medical Ce	29° Certifier (Check only one) 1 Certifying Physician: To the best of each of the part o	camination and/or in	h occurred at the time, date overtigation, in my opinion, de	and place and due to this car eath occurred at the time, da	use(s) and marrief as te te and place, and due t	state d. to the cause(s)
0	To the complete	Me	29b. Signature and title of certifier		29c. License number D62810		d. Date signed (Month,	
	(3)	V.	30. Name and address of person who completed cause of dea Azeez Abisdum, M.D. 720 31. Date filed (Month, Day, Year)	7 Hanover	Pkwy. Greenb	elt, Md. 207	08	
	Sta Regist		MAY 0 4 2006	Signature	E .			

State of Maryland / Department of Health and Mental Hygiene U U 6 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 8:44 aM Sandra M. Campbell 27,2006 4c. County of Death pril /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Forestville 3745 Donnell Dr If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 07, 1950 Wash, DC Prince George Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🛣 F Yrs. 579-68-8568 56 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County item 27 is marked other then "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examiner must be invitified at 1 Yes 2 No PG Director Forestville Md 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20747 USA 3745 Donnell Drive #104 death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after il Hygiene. other then "naturel", or Ite 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pvt Industry Nurses Asst 12th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othwany injury or other traumatic event. 17. Father's Name (First, Middle, Last) \$tanley Ellsworth Perkins Dorothy West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9313 Hobart Street Springdale, Md 20774 Mattie Jackson (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem Cem 05-03-06 Suitland, Maryland ' 4 □ Donation 5 □ Other (Specify) 21. Signature of Füheral Service Licensee 20012 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St NW Wash 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THRONT CANCINONS METASTIGU **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 97 Unknown this certificate has been signed by a director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death.

nere! Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel o 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Mile of certifier unand 143276 MAY 2) ,2006 Name and a dress of person who completed cause of death (Item 23a) (Type, Print) , MD. 6106 Old Silver hill Rd District Hghts Md.20747 MURATOR 32. Registrerie 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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	1 - For State Registrar	Sta	te of Mar	yland / I	•	ment of Ficate of		ind M	•	giene Reg. No	2000	5 157
sician	1. Decedent's Name (First,) William	Middle, Last) Francis	Donova	ın					2. Date of De Month MAY 1	Da	2006 Yea	3. Time of De 10:45
edical iminer	4a. Facility Name (If not inst. VA MARYLAND	HEALTH C	nd number) ARE SYS	STEM			RRY PO	TNIC		40	c. County of D	eath CECIL
eral tor	5. Social Security Number 325–12–4421	6. Sex 1X M 2		(In yrs. last bi		Onths Days	If Under 2 Hours	Min.	8. Date of Bir Month, Da 12/2/1	922) 11	Birthplace (State or F Country) LINOIS
ctor	Usual Residence of Decede 10a. State 10b. Co			10c. City, Tow	vn or Location							10d. Inside City 1 ☐ Yes 2
Director	10e. Street and Number 3513 Fax	m Dood			1	0f. Zip Čode 2100	,			-	itizen of What	Country?
once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 20 3 Widowed 4 Dive	12. Wa Arm Married 1 C	s Decedent Evned Forces? Kees 2 No No No No No No No No No No No No No	WWTT	If Ye	Decedent of His, specify Cuba	ispanic Orig	jin? (Spe , Puerto f	city Yes or No Rican, etc.)		J.S.A. 14. Race - A Black, W Specify: W	
Completed		edent's Education nighest grade comp 12) Col	leted) lege (1-4or 5+) б		(Give kind life. DO l	's Usual Occup d of work done NOT use retired ECTVICE	durina most	of workir	ng		Kind of Busine	
To Be C	17. Father's Name (First, Mi William Fran		van				18. Mother Edna		(First, Middle US	, Maidei	n Sumame)	
	19a. Informant's Name/Rela Rosemary Dor		,		_	ddress (Street						
	20a. Method of Disposition 1 Rurial 2 Crema 1 Donation 5 Oth	tion 3 □Remova		20b. Place o	of Dispositio	arm Rd. In (Name of or other place orest V	e) 5	/23/		20c. L		1001 or Town, State
9000	21. Signature of Uneral Se		0-	T	²² Ta	me and Addre	s of Facility	Fune	ral Ho	me,	P.A.	IS, MD
dicai Examiner	23a. Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										Approximate Interval Betwee Onset and Des UNKNOWN	
d by Physician/Mec	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 Yes 2 No 9 Unknown	1 4 4	es, outcome of Live birth 2 Pregnant at til Unknown	Fetal death		opic pregnancy her (specify)			-		23d. Date of o	delivery Day Yea
by	Part II. Other significant co	nditions contributing	g to death but	not resulting	in the under	lying cause give	en in Part I.			obacco Yes 2		to the cause of dea Probably 4 Hunk
Somp									24a. Was autor perfo 1 🗆 Yes		prior	autopsy findings ava to completion of caus ? es 2 \(\square\) No
To Be	25. Was case referred to me examiner?	Hospita	1 🔀 Inpatient	2 🗆 ER/O	utpatient 3	B DOA Oth	ar		(Check only one 5 ☐ Residue		6 □Other (Si	pecify)
Certification: T	2 Accident in	ending vestigation	Date of Injury (Month, Day	28b.	Time of Injury	28c. Injun Wor	at	2	8d. Describe			<i>cony</i> ,
Certifi	4 ☐ Homicide d	otominios	Place of Injury building, etc.	(Specify)		,			City or To	vn, Stati	e) 	Rural Route Number
Medical Certification: To Be ((Check only 2 Me		To the best of the basis of e d manner state	xamination at	je, death oca nd/or investi	igation, in my o	oinion, deat	i place, a h occurre	d at the time,	date an	d place, and d	ue to the cause(s)
5	29b. Signature and title of c	2	1.			29c. Licens	D527	39			Y 13, 2	2006
State	30. Name and address of pe SURESH SHANI 31. Date filed (Month, Day, MAY 1 8	ELYA, M.I		MARYLA s Signature	ND HE	ALTH CA	RE SYS	STEM	, PERRY	Z PO	INT, MI	21902

Please Type or Print in Black Indelible Ink
State of Manyland / Department of Health and Mental Hygiene

ann vvimann D	•	1- For State Certificate of Death Registrar	_	g. No. 200	6 57
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Adam William DePetris	2. Date of Deat Month May 11, 20	Day Year	3. Time of Death 0832 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	IVIAY 11, 20	4c. County of Death	
<i>)</i> 		601 South Main Street North East 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8 Date of Birt	Cecil h(MM/DD/YYYY) 9. Bir	holace (State or
Funeral Director		220-04-2095 1 X M 2 F 33 Yrs. Months Days Hours Min.	03/30,	Foreign	Maryland
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show d at once.	tor	Maryland Cecil North East			1 X Yes 2 No
h the Mary 3a or 28a notified at	I Director	10e. Street and Number 601 South Main Street 21901		Og. Citizen of What Cour	es
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 2 No No No No No No No No No No No No No		White, etc.	can Indian, Black,
urs afte tural",	d by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w		Specify: WIII	
336 thin 72 ho ne than "na edical Ex	npleted	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Painter	ed)	House	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica	Comple	17. Father's Name (First, Middle, Last) 18. Mother's Name		laiden Surname)	
2121: uld be fil Mental I marked c event,	То Ве	John Joseph DePetris Hope Lot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			Zip Code)
and 2 shore lealth and tem 27 is traumatic		Hope Kluttz/mother 104500 B 104 Overseas	Highway	Key Largo	FL 33037
more, MD 21215-0036 Pages I and 2 should be filed within 72 tent of Health and Mental Hygient int: If iten 27 is marked other than " r other traumatic event, the Medical.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) May		20c. Location - City or Newark, De	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		4 Donation 5 Other Specify: Mayerdale Crematory 2006 21 Signature of Furrieral Servic cen 22 Name and Address of Facility Cro)	neral Home	
	1	127 South Main Stre 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	eet,Nort	h East, Mar	cyland 21901 Approximate Interval
Physician /Medical	8 8	failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (Methadone) intoxication	roopiratory arre	or, or look, or recart	Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of): b.			
	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
760, icate be executed physician and the burial - transit	Medical	MUNPENDED AMENDED Item#23a,PII,27,28a-f,perME,g856,6/9/	/06 TT		
760, ficate be exg physician sthe burial		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan	ncv	23d. Date of delivery	ay Year
Box 687 death certification at the attending and for use as the	/sician/	past 12 months? Tive birth 2 Fetal death 3 Ectopic pregnar	ncy	Month	ay real
O. Bo it the de by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	he cause of death?
s, P.O. aires that the signed by d be detach	ed by	Paraplegia		2 No 3 Prob	
cord:	Completed		24a Was a autops perfori	sy prior to c	opsy findings available ompletion of cause of
tal Rec sian: The l certificate l ector, page		25. Was case referred to medical 26 Place of Death (Check of D	1 ✓ Yes 2		s 2 No
Vital ysician this cert	o Be	examiner?		Residence 6 🗸 Other	Scene
Division of Vital Records, tale or Attending Physician: The law require as after death. In Director: After this certificate has been sided in by the funeral director, page 2 should be a by the funeral director, page 2 should be a second to be a	on: T	1 Natural 5 Danting (Month, Day, Year)		ow injury occurred	
ivisior or Attencafter death Director:	ertification:	2 Accident Investigation TIG 5/11/2000 FIG 6:52 all 1		ngested methac treet and Number of Ru tate) OOI South N	
Div spital o	Certi	4 Homicide (Specify) Tourid Testitetic	or Town, St orth East	, Cecil, MD	ain Street
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
\$ 1 \overline{A} \	Me	29b. Signature and title of cettifier 29c License number O.C.M.E.		29d. Date signed (Mor	th, Day, Year)
	4	30. Name and address of person who completed cause of death (Item 23a)		May 12, 2006	
	i iş	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		3
S ⁱ Regis	tate trar	MILT 1 3) / III II			

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 | 5719

		1- For State Registrar		Cert	tificate of	Death			Reg No			U IU	1 1
Physici	an/	1. Decedent's Name (First, Middle,	Last)					2. Date of D		.,		3. Time of Death	1
ledical Exam	ner	Thomas Harv	ey Down	es, Jr.	•			Month May 2,	2006 2006	Year		1300 hrs	
		4a. Facility Name (if not institution,	give street and nu	mber)	- 4	lb. City, Town, or I	ocation of De		_	lc. County o	f Death		
		Easton Memorial Hospi	tal			Easton				Talbot			
Funeral		5 Social Security Number 6	S. Sex	7. Age (In yrs. las	st hirthday)	If Under 1 Year	If Under 24	Hrs 8 Date of	Birth/MN	#/DD/VVVV	9 Bid	hplace (State or	
Funeral Director		210 70 2000		48	St birtinday)	Months Days			,		Foreig	n	
Director		218-72-2000	1 <u>X</u> M 2 F	40	Yrs.			Apr.	15,	1958	Cor	untry) MD	
		Usual Residence of Decedent					•						
any		10a. State 10b. County	_	10c. City, 1	Town or Locati							10d Inside City L	Limits
rland -f show once.	ų.	MD Dorc	hester	1	Secre	etary						1 Yes 2	ΧNο
daryland 28a-f show 1 at once.	양	10e. Street and Number				10f. Zip Code			10a. Ci	tizen of Wh	at Cour	itrv?	
e Ma or 28	Director	3932 Baker R	oad				564		_	ted		•	
th th 23a notif									<u> </u>				
th wi	eral	11. Marital Status 1 Never Married 2 X Mar		edent Ever in U.S proes?		s Decedent of Hisp es, specify Cuban,			No-	14. Race - White		can Indian, Black,	
or it	Fun		1 Yes	2 X No				,,		}	0.0.		
after al", iner	by	3 Widowed 4 Divor	ced If Yes, Give Year or Dates:	r	1	Yes 2 X No	specify:			Specify:	Whi	te	
ours	D	15. Decedent's Education (Specif	y only highest grad	le completed)		's Usual Occupations of working life.			16b.	Kind of Bus	iness/Ir	ndustry	
72 h n "n	eted	Elementary/Secondary (0-12)	College (1	-4 or 5+)		ū		retired)		1			
036 thin 72 ne. • than fedical	np	1 2			Seli-	employe	e a		5	hop .	ror	eman	
15-0036 filed within 72 Hygiene. d other than "	Comple	17. Father's Name (First, Middle, L	ast)			11	8.Mother's Na	me (First, Midd	e, Maidei	n Surname)			
215 e filo tal H ked o	Be (Thomas H. D	ownes,	Sr.			Doris	s Pucke	ett				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	.o E	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailing	Address (Street	and Number	or Rural Route	Number. (City or Town	State	Zin Code)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menlal Hygien and Menlal Hygien of 17 is marked other than "natural", or items 23a or 28a-f she mastic event, the Medical Examiner must be notified at once	_	Jana P. Downe		5.0		Box 399				•		Zip Gode)	
, M and 2 salth em 2 raur		20a. Method of Disposition	5/ Spou			tion (Name of cem		Date		Location -		Town State	
ore of He If it		1 Burial 2 X Cremation	3 Removal fro	om State Cr	ematory or oth	er place)					,	,	
Page Page nent (4 Donation 5 Other Spe		Mi	d-Shor	e Crem	.Ctr 05	5/07/06	C	ambri	dge,	, MD	
alti mit sartm ports ury o		21. Signature of Funeral Service L			22. N	ame and Address	of Facility	omp+om	Funa	nol II		D 1	
Baltimore, MD 21 permit Pages I and 2 should I Dopartment of Health and Mer Important: If item 27 is man injury or other traumatic eve		Michael t.	Signature of Funeral Service Licensee Wilhard F. Galrow 22. Name and Address of Facility Framptom Funeral Hom 216 N. Main St., Federalsburg, MD										
Physician		23a. Part I. Enter the disease, or co	040	aused the death. I								Approximate Int	terval
/Medical		failure. List only one cause o						, ,				Between Onset Death	
xaminer		Immediate Cause (Final disease or condition resulting in death)				ovascular Dise	ease					Deam	
		or condition resulting in death)	Due to (or as a	consequence of)									
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68760, ertificate be iding physici	2	23b. Was decedent pregnant in the	1 Live b	outcome of pregna		al death 3	Ectopic pre	anancy	23	Bd. Date of o Month		ay Year	
certif certif anding use as	cia	past 12 months?		ant at time of dea	th -			griaricy	- 1	MOTILIT	D.	ay Year	
Box e death c the atten ed for us	ysi	1 Yes 2 No 9 Unkn		own	5 Otr	ier (Specify)							
, P.O. Box 6 res that the death ce signed by the attend be detached for use	Physicia	Part II. Other significant conditio	ns contributing to	death but not res	sulting in the u	nderlying cause gi	ven in Part I	23e. Di	d tobacco	use contrib	ute to t	he cause of death	12
P.O	by	•							Yes 2		_	ably 4 🗸 Unkno	
S, uires n sig													
Division of Vital Records, tall or Attending Physician: The law requirant based each. In Director: After this certificate has been seled in by the funeral director, page 2 should I	Completed							24a W	as an topsy			opsy findings avai empletion of cause	
tal Recolinam: The law certificate has	m						-	pe	rformed?	de	eath?		
Rec : The ificate r, page		25. Was case referred to medical	_			00 81	- f D II- (OI-		s 2	No 1	✓ Yes	s 2 N	0
tal ician cert	Be	examiner?	Hospital:				of Death (Che						
F Vi Physi r this	P	1 Y Yes 2 No		npatient 2 🗸 E				rsing Home 5			Other:		
n of ding Ph	Ë	27. Manner of Death 1 ✓ Natural 5 □ Rendir	28a. Date (Month,	of Injury , Day,Year)	28b. Time of Ir		y at Work?	28d. Descrit	e how in	jury occurre	d		
ior tend tor:	aţi	1 Natural 5 Pendir 2 Accident Investi				1 Y	es 2 No						
ivisior for Attend after death Director:	Ę	3 Suicide 6 Could	28e Place	e of Injury - At hor	me, farm, stree	t, factory, office bu	uilding, etc.			and Number	or Rur	al Route Number,	City
Div	Certification: To	4 Homicide determ						or Town	i, State)				
		29a Certifier	sician; To the bes	t of my knowledge	e, death occur	ed at the time dat	e and place s	and due to the o	ause(e) a	nd manner o	as etart	ad.	
To the Howithin 24 Paragraph To the Function Completely	Medical	(Check only one) 2 Medical Exam											
To 1 To 1	Ned	29b. Signature and title of certifier	and manner st			29c. License						`	
	-	(24	- (th, Day, Year)	
		Tabully	much +	010.1	~ 1/-0	O.C.N	/I. E.		Ma	y 3, 2006	+		
		30. Name and address of person w	no completed caus	se of death (Item 2	23a)								
		Patricia Aronica-Pollak	MD. Assista	ant Medical E	xaminer	111 Penn Str	eet, Baltim	ore, MD 212	201				
s	tate	31 Date filed (Month, Day, Year)		gistrar's Signatur	e A	start or							
	trar	MAY E 2	006	2000 DE 1	e for	150							

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** May 6, 2006 Findlay 2:15 pm Elizabeth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 2, 1926 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 ☐ F MO 215-20-6987 79 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD Washington Hagerstown 1 Yes 2 □ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19630 Cool Hollow Road 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home . c., Marylanc.
. c., Marylanc.
. c., marylanc.
Department of Health and Mental Important; if itam 27 ie ...
any injury or oth.
2006. traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Conway James Conway ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19630 Cool Hollow Rd Hagerstown MD 21740 Craig Robinson son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Hillcrest Memorial Park 5/9/2006 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cete has been signed page 2 should be der Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tyes 2 □ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificete 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending investigation death. 1 □Yes 2 □No 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the h 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 8 2006 Registrar

DHMH 17 Rev 1/2001

Registrar

			State of M	laryland / Department of H		lental Hygie	ne2006	15722
			1. Decedent's Name (First, Middle, Last)	Certificate of	Death	Reg. 2. Date of Death	No.	3. Time of Death
п	Physicia	an		TD		Month	Day Year	
	/Medic Examin		FRED MONROE GUICE, 4a. Facility Name (If not institution, give street and number		r Location of Death	MAY 12,	2006 4c. County of Deat	7:10PM ^M
	examin	er	SOUTHERN MARYLAND HOS					
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	GEORGE 'S
	Director		578-38-2686 XX 2□F	75 Yrs. Months Days	Hours Min.	(Month, Day, Ye		untry) UTH CAROLT
	P P		Usuel Residence of Decedent 10a, State 10b, County	10c. City, Town or Location				10d. Inside City Limits
	aho et e	ŏ						1 Yes 2 No
	28a-1	Director	MARYLAND PRINCE GEORGE 10e. Street and Number	S UPPER MARLBO	RO	100	Citizen of What Co	
	deeth with the Maryland ima 23a or 28a-f ehow ir must be notilitied at	ā	9111 GOLDEN ROD LANE	207	7.2			_
	ma 2	Funeral	11 Marital Status 12. Was Decedent	Ever in U.S. 13. Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	rican Indian,
9	after or Its		Armed Forces 1 Never Married XXMarried 1 X Yes 2 1 If Yes, Give	No 1 Van OVIVIA	Specify:	Hican, etc.)	Black, White	
5-003	hours after tural', or ite	d by	3 Widowed 4 Divorced Year or Dates:	KOREA TO THE SECTION	эрвспу.		Specify: WH	ITE
2	nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of work	ing 16b	. Kind of Business/	industry
7	within 72 ene. than "nat	ш	Elementary/Secondary (0-12) College (1-4or	5+)	")	_		
מ	filled Hygi other	ပို	17. Father's Name (First, Middle, Last)	PLUMBER	18. Mother's Name	(First, Middle, Maid	OCAL #5 den Sumame)	
<u>a</u>	lid be lental ked d	To Be	FRED M. GUICE, SR.		MAE SI	INGLETON		
Maryland	should be made with the second	_	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street			ty or Town, State, 2	ip Code)
	and 2 alth a 27 L		THURIDUR GUICE-SPOUSE	9111 GOLDE	N ROD LI	J., UPPER	MART.BOX	RO.MD20772
Baltimore,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ∑ Kremation 3 ☐ Removal from State	20b. Place of Disposition (Name of	; [Date 20c	. Location - City or	Town, State
Ĕ	Pa ant: ury			ROPOLITIAN CREMA	TORY 5-1	.5-06 A	LEXANDR	[A, VIRGINI
3a	Depart Import eny in		21. Signature of Funeral Service Licensee MOO	479 22. Name and Addres		SERVIC	מ כו ים	
	205 • a		23a. Part1. Enter the disease, or complications that cause					
п			shock, or heart failure. List only one cause on each I	ine.				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Stage Cardior	uyopat	ny		> year
	Examiner		Due to (or as	estive heart	Failure	2		> Sugarc
	Ž.	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	s a consequence of):				12902
	d d ansit	Examine	cause. Enter Undertying Cause (Diseese or injury that initiated events	s a consequence of): te revel fail s a consequence of):	lure			> I week
Ö,	be executed sician and burial-transit	Ex		is a consequence of):	D.	" Cours . all		72014
8760	cate be	dical	. Chvou	ic obstructive	Volmo	naig a	icease.	1 20 years
9		a	IF FEMALE:					
ROX	attend for us	lan	23b. Was decedent pregnant in the past 12 months? 1 Vac 2 Na 4 Pregnant 4	2 ☐ Fetal death 3 ☐ Ectopic pregnancy			23d. Date of deli	very Day Year
o.	that the death certif ed by the attending detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	tt time of death 5 Other (specify)				
J	The law requires that the death certificate has been signed by the attending sage 2 should be detached for use as	by Pt	Part II. Other significant conditions contributing to death t		en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
g	w requires been signi should be	g p	Peripheral Nascula			1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
ပ္တ	s been 2 shoul	piet	Aortic Abdominal	Aneuvysm.		24a. Was an	24b. Were au	opsy findings available ompletion of cause of
ř	The I	Completed	Chronic Kidney &	usease		autopsy performed	? death?	ompletion of cause of 2 No
Vital Records,	sician: The law certificete has b irector, page 2 s	Bec	25. Was case referred to medical examiner?		26. Place of Death		110	
ot S	hysic his ce	10	1 ☐ Yes 2 ☐ No Hospital: 1 Xnpati		4 La Nuising Hor	me 5 Residence		ify)
Ĕ	ding Phys	io io	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injuty. (Month, Date of Injuty).	ay Ye <i>ar)</i> Injury Work	c?	28d. Describe how in	njury occurred	
<u>s</u>	Attendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	jury - At home, farm, street, factory, office	Yes 2 □No	28f. Location (Street	and Number or Ru	ral Cauta Number
Division	after after Direction	Certification:	4 Homicide determined 289. Place of the building, e	tc. (Specify)	,	City or Town, St	ate)	ai Houle Number,
	To the Hoapital or Attending Physician: which 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death occurred at the time	ne, date and place, a	and due to the cause	e(s) and manner as	stated.
	n 24 l	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner st	of examination and/or investigation, in my or	pinion, death occurre	ed at the time, date a	and place, and due	to the cause(s)
	To t. Withi	Σ	29b. Signature and title of certifier	le my 29c. License	number	29d.	Date signed (Month	Day, Year)
			Mein 6. Cleenpa	he my D43	2049	M	my 121	, 2006
	1141		30. Name and address of person who completed cause of	death (Item 23a) (Type, Print)	()nno-	Manl	bovo 1	, 2006 UD. 2077
			/ (55 . 5	rar's Signature	Opper	V V CCCCC	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Sta Registr		MAY 1 8 2006	M. Jack B				

					ryland / Dep			•	•	
			1 - For State Registrer			rtificate of I			leg. No.	6 15/23
			1. Decedent's Name (First, Middle, Las	t)			-	2. Date of Dea Month		3. Time of Death
	Physici /Medio		EDWIN WALLAC	E GATEW	DOD			MAY	11 200	1.4
	Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of D	
			135 Wilson St.	7.4	Manage to a block to the	Cecil		0.000	Ceci	
	Funeral Director		5. Social Security Number 6. Security Number 1218-28-3283	ox /.Age MgM 2□F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)	Birthplace (State or Foreign Country)
	_		Usual Residence of Decedent					Oct 30	1928	Maryland
	rylan	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma Ba-f s	cto	MD Cecil		Ceci1te	on				1⊠Yes 2□No
	with the	Funeral Director	10e. Street and Number			10f. Zîp Code			log. Citizen of What	Country?
	s 23	eral	135 Wilson St.	12. Was Decedent E	wor in II S 12	21913		noity Von or No	U.S.A.	merican Indian,
	fter d	Fun	11 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	0	If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	Rican, etc.)		/hite, etc.
93	at', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2½ DNo	Specify:		Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. than "naturat", or itams 23e or 28e-f show the Medical Examinet must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of Busine	ss/industry
7	vithin ne. han *	dm	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retired	during most of work i)		Agricu1	
22	iled v Hygie thar t		17. Father's Name (First, Middle, Last)		Tr	uck Dri	Ver 18. Mother's Name	/First Middle	Product	S
and	d be f	o Be	John Raymond G	atewood					Edward	C
Maryland	shoul nd Me mari	2	19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street a			r, City or Town, Stat	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "naturat", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.		Mary Gatewood	(sister) P.O	. Box 3	78 Ceci	lton,	MD. 219	13
Je,	as 1 a		20a. Method of Disposition	D 1/ 0: :	20b. Place of Dispo cemetery, cre			Date	20c. Location - City	
Ē	Page nent c ant: tf ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		Union B		13/20	706	Cecilt	on, MD.
Baltimore,	permit. Departr Imports any inj		21. Signature of Funer US avice licen	8//	2: G	2. Name and Addres	ss of Facility	ome of	Stepher	n L Schaech
ш	g Q E 9 9		7700	MO	0510 1	18 West	Cross S	t. Gal	ena, MD	. 21635
п			23a. Part Enter the disease, or compositions, or hear failure. List only	plications that caused to one cause on each line	the death. Do not en	er the mode of dyin	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. p ~ 0	state	cance	er			3vours
H	Examiner		1	The to (or as a	consequence of):					/
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4	outed and a	Examiner	that initiated events	C.						
,092	ate be executed hysician and he burial-transit	Exi	resulting in death) Last	Due to (or as a	consequence of):					
876	ate b	ilcal		d.						
x 68	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome o	f prognancy					
Вох	eath c attender for us	lan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
P.O.	the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ino or doding					
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Pł	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
rds	w require been sig should b	ed b	l'abetes Me	164445	type 2			1 □ Y	as 2 0 √√0 3□	Probably 4 Unknown
Vital Records,	law re as be	Completed	Hupertens	ion				24a. Was a		autopsy findings available to completion of cause of
Œ.	The ate ha	Com						perform	med? death	?
/ita	cian: ertitic actor,	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only on	θ)	
of	ding Physician: The law h. After this certiticate has funeral director, page 2	LO.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Outpatier		4 🗀 Ivuising noi		ence 6 Other (S	pecify)
LO	ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day		Work	/at ⟨? Yes 2 ∐No	280. Describe no	w injury occurred	
Division	Attanding r death. actor: After by the fune	fica	3 Suicide 6 Could not be	280. Place of Injul	ry - At home, farm, str					Rural Route Number,
ă	al or safter	Certification:	4 Homicide determined	building, etc.	(Specify)			City or Town	n, State)	
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely tilled in by the		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	vsician: To the best of	my knowledge, deat	n occurred at the time	ne, date and place,	and due to the ca	ause(s) and manner	as stated.
	tha H in 24 tha Fi	edical		and manner stat	ed.			ed at the time, d	ate and place, and c	lue to the cause(s)
Ł	To To COUT	Σ	29b. Signature and title of certifier	/		29c. License	3577	7 2	9d. Date signed (Mo	- m
			Vasoue	ushan	~		10/7/		my 10	7006
	6		30. Name and address of person who o		, , , , , ,					01013
	Sta	tė	W. Bruce Oben	shain MD 2. Registra	's Signature	. 7	ia Ave.	Cecilt	on, MD.	21913
	Registr		MAY 1 8 2008	100	1. Apar	(i)				,

			For State Registrar	State of Ma	aryland		artment rtificate			nd Me		giene Reg. No.	211116	15724
			Decedent's Name (First, Middle, Las	t)						1	2. Date of De	ath		3. Time of Death
	Physicia		Lucy Marie Gonz	zalez							Month May	Day 2 ,	у _{Үөаг} 2006	6:55 P M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, To	own, or i	Location of	f Death	1100		County of Death	
	<u>"</u> Admin	CI	Montgomery Hospid	ce- Casey	House		Ro	ckv:	ille				Montgome	ery
	Funeral		5. Social Security Number 6. Se	7. Age		st birthday)	If Under 1		If Under 2		B. Date of Bir	th Year)	9. Birth	place (State or Foreign
	Director		111-22-1523	□M 2점F	86	Yrs.	Months	Days	Hours	Min.	Jan. 8	, 19	20 Pu er	to Rico
	σ		Usual Residence of Decedent											
	how		10a. State 10b. County			Town or Lo								10d. Inside City Limits
	B Ma	cto	Maryland Montgor	nery	Silv	er Sp	ring							1 ☐ Yes 2 🖾 No
	72 hours after death with the Maryland Inatural; or Rema 23e or 28e-f ehow dreal Examinat must be notified a	al Director	10e. Street and Number 3114 Gracefield	Road, Apt	. 220)	10f. Zip C 2 C	ode 0904				10g. Citi	izen of What Cou USA	ntry?
	deat	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S	i. 13. \	Was Deceder	nt of His	panic Orig	in? (Spec	ify Yes or No		14. Race - Ameri Black, White,	
9	after or Ita	E	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N	lo						o Rica	n		nite
8	ours raf,	d by	3 ☐Widowed 4 ☐ Divorced	Year or Dates:			M 163 51		Specify.F	uerc	- KICa	11	Specify. W1	11.00
21215-0036	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		(Give	dent's Usual i kind of work	done du	uring most	of working	7	16b. Ki	ind of Business/Ir	ndustry
2	ithin	ם	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use	,		- ah o			Educat	ion
7	ygier ygier her ti		ATT THE RESIDENCE OF THE PARTY	5+		Forei	gn Lan				L 'First, Middle	14-14		.1011
land	uld be fi fental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Last) Felix Camps										Gonzale	ez
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene 1 them 23s or 28s - 1 show then trains at the notified a cother traumatic event, the Michael Examinar most be notified a	9 3	19a Informant's Name/Relationship (7) Karen M. Gonzalez		hter		-						or Town, State, Zip Spring,	Code) MD 20904
Baltimore,	uges 1 ar or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	Cel	metery, cren	sition (Name natory or oth National	er place		Da May	7 8,		ocation - City or T	
를	rtent		4 ☐ Donation 5 ☐ Other (Specify 21. Signature ★ Funeral Service Licen					006			Virginia			
Ba	permit. Pages 1 Department of H Importent: If Ite eny injury or ot once.		16 bertE1	Came	2	ity E	ns r	uneral W, Si	lver	Spring,	MD 20901			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each in	the death. ie.	Do not ent	er the mode	of dying	, such as c	cardiac or	respiratory a	rrest,		Approximate Interval Between
46	Physician	Ü 9	Immediate Cause (Final disease or condition	Gall E	31adde	er Can	cer							Onset and Death
	/Medical		resulting in death)	Due to (or as	a conseque	ence of):								
	Examiner		Sequentially list conditions,	b										
	D #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):								
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60,	cate be executed bhysician and the burial-transit	E	Tosaking in county cast	Due to (or as	a conseque	ance of):							1	
87	physi	dlcal		d							· · · · · ·			
9 x	n certific anding p use as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnan	icv	0.00						COL Para di dalla	TI-5
Вох	att att	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal o	death 3□	Ectopic pred Other (spec					1	23d. Date of deliv Month	ery Day Year
o.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or dea	a 5_	J Other (spec	July/						
<u>α</u>	that t	문	Part II. Other significant conditions of	ontributing to death be	ut not result	lting in the u	nderlying cau	ise dive	n in Part I.		23e. Did t	obacco u	use contribute to t	he cause of death?
of Vital Records,	w requires that the been signed by th should be detache	ed by									10	Yes 2	ĎNo 3□Prol	bably 4 □Unknown
ecc	aw as b	Completed									24a. Was autoj	Sy	prior to co	opsy findings available ompletion of cause of
<u> </u>		S									1 Yes	med? 2⊠ No	death? 1 ☐ Yes	2 □ No
ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?					1 -		of Death (Check only o	ne)		
<u></u>	Physic this o	၉	1 ☐ Yes 2 ☑ No				t 3□ DOA		4 🗀 1401				6 ² DOther (Special	hy) Hospice
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	Year) 2	28b. Time of Injury	280	c. Injury Work		1	d. Describe	now injur	ry occurred	
Sio	E ta :: e	cat	2 ☐ Accident investigation				М	1 🗆 Y	es 2 N	10				
Division	il or Atten after deat I Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ury - At hon c. <i>(Specify)</i>	ne, farm, str	eet, factory, o	office		28	If. Location (City or To		nd Number or Rur 9)	al Route Number,
	To the Hospital or Atternation 24 hours after de To the Funerel Directo completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of niner: On the basis of and manner sta	examination	vledge, death on and/or in	n occurred at vestigation, in	the time	e, date and inion, deatl	place, an	d due to the d at the time,	cause(s) date and	and manner as s d place, and due t	stated. o the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier				29c. l	License					te signed (Month,	
)	*15		1/4/	\sim	~	17		a35	635				May 3, 20	
	MAG.		30. Name and address of person who Joseph Kaplan, M.					Road	l, Roc	ckvil	le, MD	208	355	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 2	32 Registra	ar's Signatu	ure do	whi)							

State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 12:03 AM Joan Higgins Graham May 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 40 Williams Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 LE Director Yrs. 218-50-8714 56 July 9, 1949 Florida Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rel', or items 23a or 28a-f ehow Examiner must be notified at 10d, Inside City Limits 1 X Yes 2 □ No Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 Williams Drive 21401 filed within 72 hours after death Hygiene. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White "naturel", 3 Widowed 4 Divorced Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Trave1 permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If Item 27 is marked othe eny lighty or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Herbert Higgins Betty Brehm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Williams Drive Graham, Jr. / Husband Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 5/3/2006 Brentwood, Maryland 21. Signature of Funeral Sergice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical for use IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death signed by the al 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 autopsy performed certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No Director: 2 Accident To the Hospital or Attal within 24 hours after das To the Funeral Director completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 21438 completed cause of death (Item 23a) (Type, Print) DEFENSE HEAWAY ANDROUS CLENT Man 445 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State MAY 0 3 2006 Registrar

		For State Registrar	State	of Marylar	•	artment rtificate			and M		giene Reg. No.	2006		726
Physic		1. Decedent's Name (First, Middle James Wellin		tt						2. Date of Dea Month May 5	ath	O6		of Death
/Medi Exami		4a. Facility Name (If not institution				4b. City,	Town, or	Location o	of Death			County of Death		<i>J</i>
		19056 Piney Po	int Road			V.	a11e	y Lee	2		5	St. Mary	's	
Funeral		5. Social Security Number	6. Sex 1 → M 2 □ F	7. Age (In yrs.	•	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	v. Year)			or Foreign
Director		228-12-0147 Usual Residence of Decedent			85 Yrs.					May 16	, 19	20 Ma	rylano	<u>d</u>
Maryland	tor	10a. State 10b. County Maryland St. M	ary's	10c. C	ity, Town or Lo	valle	y Le	e					10d. Inside 1 ☐ Ye	City Limits
th the or 28¢	Olrec	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Cou	intry?	
ath wi	ra	19056 Piney Po					2069				,	USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel", or itame 23s or 28e-1 ehow any Injury or other traumatic event, the Madical Examinar must be notified at another.	by Funeral Director	11. Marital Status 1 □ Never Married 2 🖾 Marr 3 □ Widowed 4 □ Divorced	ied 12. Was Dec Armed F 1 Tyes If Yes, G Year or I	edent Ever in Lorces? 2 X No ive Dates:		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)		14. Race - Ameri Black, White Specify: Wh	etc.	
hin 72 hores.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	st grade completed,	(1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ition luring most }	t of workin	ng	16b. Kir	nd of Business/Ir	ndustry	
ed with	Con	12			Tax	Asse	ssor					land Stat	e Gover	nment
yland buld be fil Mental H arked ott atic even	To Be	17. Father's Name (First, Middle, Herman Walter						Mign	onet		alia	Goodwin		
and 2 shall and a 27 is m		19a. Informant's Name/Relations Margaret Ernestine			19056	Piney	Point	Road,				r Town, State, Zij and 20692	o Code)	
Pages 1 tent of He nt: If Iten		20a. Method of Disposition 1		I State	Place of Dispo cemetery, cre 1y Fac			1		, 2006		cation - City or T		
permit. Departm Importe any Inju		21. Signature of Funeral Service	Licensee far	dine						uneral H town, MD				
Physician /Medical Examiner physicieu and the burial-transit	ical Examiner	23a. Pant l.Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to	caused the dead atch line.	quence of):	ter the mode	a of dying	g, such as	cardiac of	respiratory ai	rrest,		Approxim Interval B Onset an	d Death
The COLORS, T.O. DOX OD FOU, The law requires that the death certificate be executed the hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transitions.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregribinth 2 Fet pregrimmer at time of nown	al death 3	□Ectopic pre □ Other (spe					2	23d. Date of deliv Month	ery Day	Year
w requires that been signed b should be deta	۵	Part II. Other significant condition	ons destinuting to	eath but pot re	setting in the c	in whying ca	ause give	on in Part I.		23e. Did to	obacco u	/	he cause o	
The law rec	Completed			<u>.</u>								24b. Were autoprior to codeath?	opsy finding ompletion of 2 \square No	is available cause of
VICION: Icion: Sertifice	Be	25. Was case referred to medica examiner?					0.1		of Death	(Check only o	ne)			
VISION OF VITA Attending Physicien: or death. ector: After this certific by the funeral director,	၉	1 Yes 2			28b. Time of			4 140		ne 5 Resid		Other (Speci	fy)	
oding th: After	to Li	1 Natural 5 Pendir		of Injury nth, Day Year)	Injury	м	8c. Injury Work	?" Yes 2 □ 1		od. Describe i	iow injury	y occurred		
at or Atters at the control of the c	Sertification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Plac	e of Injury - At I ding, etc. (Spec	nome, farm, st	reet, factory	, office		2	8f. Location (S City or Tox	Street and vn, State)	d Number or Run	al Route Nu	ımber,
To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2:	edical C	29a. Certifier (Check only one)	g Physician: To the Examiner: On the and ma	basis of examin nner stated.	owledge, deal	th decurred to	at the tim	rs, data am pinion, deal	d place, a	nd due to the ed at the time,	caus (s) date and	and manner as s place, and due t	stated. o the cause)(s)
To the Vithin To the Comp	W	29b. Signature and title of certifie	200-1	M		290	License	mamber/	98		29d. Date	e signed (Mgňth,	Day, Year)	
		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type	Print)					+			
		David M. Federle,		5 Three N		ad, Holi	1ywoo	d, MD	20636					
Si Regis	tate trar	31. Date filed (Month, Day Year)	9 2006	e gistrar's Sign	A A	port								

			For State Registrar	State of Ma	aryland		artment of tificate of			ental Hy	giene Reg. No	2000	15727
. 9	Physicia	an l	Decedent's Name (First, Middle, La						1	Date of De Month	eath Da	y Year	3. Time of Death
	/Medic		Mattl		mes	Ноє	ltje			May (01,	2006	1207 p ^M
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town,				40	. County of Deat	
	8a - 8,	~	7 Ninth Avenu		e (In yrs. las	t birthdav)	If Under 1 Yea	unswi		3. Date of Bi	rth	Freder	
	Funeral Director			1 □ kM 2□ F	36	Yrs.	Months Days	s Hour	s Min.	(Month, D	ay, Year)		hplace (State or Foreign untry) rvland
	D.	ļ	Usual Residence of Decedent						1 14	iug. 2		505 11d.	
	nylan show	_	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f.	octo	Maryland Frede	rick	Brur	nswic					10 0		
	with ti	2	10e. Street and Number #7 Ninth Avenue				10f. Zip Code 21716				10g. Ci	tizen of What Co USA	untry?
	be filed within 72 hours efter death with the Maryland tal Hygjene. d other then "natural", or items 23s or 28s-f show event, I'm Medical Examinat must be inclifted at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	. 13.1		Hispanic	Origin? (Spec	rtv Yes or N	0-	14. Race - Ame	nican Indian,
_	r Item	F	1 ☐ Never Married 2 🗷 Married	Armed Forces?	2		Was Decedent of f Yes, specify Cu			ican, etc.)		Black, White	
3	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 N	o Spec	rify:			Specify: Wh:	ıte
21215-0036	natural disal	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual Occi	e durina m	nost of working	g	16b. K	(ind of Business/	Industry
2	within 72 ene. than "nat	du	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retirent stations S		vicer		Sahu	atom Con	
2	filed v Hygie other t	ပိ	17. Father's Name (First, Middle, Las			opera	actons s		other's Name		-	ster Cor	icrete
au	d be f) Be	Richard Hoeltje						orah Gr				
Maryland	should be tand Mental I smarked o	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	et and Nun	nber or Rural	Route Numl	ber, City	or Town, State, 2	Zip Code)
	and 2 seeth ar n 27 is		Lori L. Smith-Ho		e	#7 N	inth Ave	nue,	Brunsv	vick,	Mary	land 21	716
ē,	s 1 au if Hee item othe		20a. Method of Disposition		cen	ce of Dispo	sition (Name of matory or other p	lace)	Da		20c. L	ocation - City or	Town, State
Ë	Pages nent of ant: If it		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec				aven Cemet		May 2006	5,	Sil	ver Spr	ing, Maryland
Baltimore,	permit. Pages 1 and 2 should be Deportment of Heelth and Menta Important: If item 27 is marked any injury or other traumetic evonce.		21. Signature of Funeral Service Lice Neckend L	lales		F 5	rancing Ad 00 Unive	ress ජර්ද rsity	filins E y Blvd,	Tunera W, S	l Ho	me Inc r Spring	g, MD 20901
	7 *		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause	d the death.	Do not ent	er the mode of d	ying, such	as cardiac or	respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		_	ت (ما:	vound to	hoad	1				Onset and Death Immediate
	/Medical		resulting in death)	Due to (or as			vodiki to	iicac	<u>.</u>				THINICOTALE_
U	Examiner		Sequentially list conditions.										
	po is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):							
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a conseque	ence of):							
760,	be ey	ical E			, , , , , , , , , , , , , , , , , , , ,								
687	ficate phys s the	dic		_ d									
	Attending Physicism: The law requires that the death certificate be executed rideath. Getor: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7-					23d. Date of del	ivery
P.O. Box	death e ette d for	cia	in the past 12 months?	1∐Live birth 4☐Pregnant a			⊒Ectopic pregnar ⊒ Other (specify)	ncy				Month	Day Year
0	at the de by the	hys	9 Unknown	9Ll Unknown									
	res tha signed be det	by Р	Part II. Other significant conditions	contributing to death t	but not result	ting in the u	nderlying cause	given in Pa	art I.	23e. Did	tobacco		the cause of death?
ğ	v require been si should I									1 🗆	Yes 2	No 3□Pr	obably 4 Unknown
Records,	e lawr has be je 2 sh	Completed								24a. Wa auto	opsy	prior to	topsy findings available completion of cause of
<u> </u>	The sete h page	Con								peri 1 ☐ Yes	formed? 2 X No	death? 1 ☐ Yes	2 🗆 No
ij	Attending Physicisn: The prideath. •ctor: After this certificate his by the funeral director, page	Be	25. Was case referred to medical examiner?						ace of Death	(Check only	one)		
5	Physic this o	2	1 XYes 2 No	Hospital: 1 Inpati			IL SU DOA					6 ☐Other (Spe	cify)
S	ding f h. After funer	lon	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time o Injury Lコヘフ I	W	juryat /ork? ∐Yes 2		8d. Describe		shot sel	f
S	death death ctor: y the	ficat	2 Accident investigat: 3 Suicide 6 Could not	be 300 Bloom of In	2006 1		reet, factory, offic			8f Location	/Street a	nd Number or Bi	ural Route Number
Division of Vital	after after Dire	Certification:	4 ☐ Homicide determine	building, e	tc. (Specify)		nome	-		City or To	own, Stat	[⊛] 7 Nint	:h Avenue
	To the Hospitel or Attendi within 24 hours after death. • To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Cartifying F (Check only one) 2 Medical Exp	Physician: To the best aminar: On the basis of and prapagers	of examination	rledge, deat on and/or in	th occurred at the	time, date y opinion,	and place, and death occurre	nd due to the	e cause(s	ick, Mar s) and manner as nd place, and due	stated.
	o the	Me	29b. Signature and title of oertifier	2//	1	1	29c. Lice	nse numb	er		29d. Da	ate signed (Mont	h, Day, Year)
	- 5 - ö) / oll.	HU	100	U)) D3	3 71 97			M	May 01,	2006
•	>		30. Name and address of person wh	o completed cause of	death (Item	23a) (Type.	Print)					- ,	
			Alan H. Rohrer,		. ,			h Str	ceet, F	reder	ick,	Marylar	nd 21701-450
	Sta		31. Date filed (Month, Day, Year)		trar's Signatu	nte /	sile!						
9	Regist	rar	MAY 0 4	2006	w D	149							
CAL	49 49 1 4 7 Day 4 10	004											

DHMH 17 Rev 1/2001

			For State Registrar	State of M		d / Depa		t of H	lealth a	and M	-		2006	15728
Phy:	cicia	_	1. Decedent's Name (First, Middle, La	,							2. Date of De	ath		3. Time of Death
	edica		ELIZABETH HASSETT								Month MAY	1 ^{Day}		
Exa	mine	er	4a. Facility Name (If not institution, gir MORNINGSIDE HOUSE O)		4b. City,		Location o	of Death			County of Dea	
Fune	ral		5. Social Security Number 6.	Sex 7. A	ge (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Birt	th	INCE GEO	
Direct			577 - 38-5869	1□M 2ሺF	83	Yrs.	Months	Days	Hours	Min.	(Month, Da 3/25/19			rthplace (State or Foreign Country) HINGTON DC
and **		}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Manyll f eho		ğ	MARYLAND PRINCE G	EORGES		AUREL								1 ☐ Yes 2 ☑ No
r 28e		rec	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What C	country?
th wit		Funeral Director	7700 CHERRY LANE				20	0707				US	A	
teme		ne	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13. \	Was Deced	lent of Hi	ispanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi	
rs afte		by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 Yes 2 N If Yes, Give Year or Dates:	No		1 □ Yes 2	2⊠ No	Specify:				Specify:	HITE
2 hou			15. Decedent's E	ducation		16a. Deced	dent's Usua	I Occupa	ation			16b. Ki	ind of Business	
thin 7		Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or	5+)	life. L	kind of wor DO NOT us	e retired)		ng			,
led w tygien her th			12			ADMIN	[STRAT]	IVE A					YATT HOTE	EL
d be fi	1	Be	 Father's Name (First, Middle, Last JAMES HASSETT. 	7						ers Name EN BAI	(First, Middle,	Maiden	Sumame)	
ally idilic X I X I 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than 'naturel', or iteme 23e or 28e-f ehow umatic event, the Medical Examinar must be notified a	'	္	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address	(Street a			I Route Numbe	er. City o	r Town. State.	Zin Code)
and 2 ealth a m 27 is			NANCY E. EDGAR - DA	UGHTER							CITY FL			- p - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0 - 0
Pages 1 and the ment of He mont of He mut. If item	2		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Domaval from State		ace of Dispo	sition /Nam	ne of			ate		ocation - City or	r Town, State
Definition Definition Department of Moortant: If it no injury or o	V		4 Donation 5 Other (Speci			E OF HE	AVEN C	EMETE	RY 5	5/5/20			ER SPRING	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Iteme 23a or 28e-1 show any injury or other traumatic event. Ite Medical Examinar must be notified.	Suc		21. Signature of Funeral Service Lice Muselun 1. W	lebert	-	11	. Name and 800 NE	d Addres W HAM	s of Facility	HIN AVEN	ES-RINALI UE; SILV	DI FU ER SP	NERAL HO	ME 20904
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each l	d the death	. Do not ente	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
Physicia	_		Immediate Cause (Final disease or condition resulting in death)	a CORONA	RY ARTE	ERY DISE	EASE							Onset and Death
/Medic Examin	_		resulting in death)	Due to (or as										
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cate by charge by the but		cal	•	d										
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death death death		Pnysician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant a	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date of de Month	livery Day Year
et the	,	5	9 Unknown	9□ Unknown										
res the signed be de		2	Part II. Other significant conditions	contributing to death t	out not resul	Iting in the ur	nderlying ca	ause give	n in Part I.					o the cause of death?
requi		ered				-					1 1 1	es 24	∐No 3 □ P	robably 4 Unknown
ne taw hes t		Completed									24a. Was autop		24b. Were a prior to death?	utopsy findings available completion of cause of
in: The Tripa or, pa		် မ	25. Was case referred to medical						00 PI	10 "	1 Yes	2 14No	1 Yes	2 🖺 No
ysicia ysicia is cert direct	3	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 E	R/Outpatien	t 3□ DO	A Othe			<i>(Check only o</i> ne 5 ☐ Resid		3 Mother (Sne	acity)
ding Ph After th funeral			27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju	iry Year)	28b. Time of Injury	28	Bc. Injury Work			8d. Describe h			No.
U U U U U U U U U U U U U U U U U U U		cat	2 Accident investigatio 3 Suicide 6 Could not b				М	1 🗆 Y	res 2□N	No				
al or Ai		Certification:	4 Homicide determined	28e. Place of in	jury - At hor tc. <i>(Specify)</i>	me, farm, stre	eet, factory,	, office		2	8f. Location (S City or Tow	Street and m, State,	d Number or R)	ural Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		edical	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best miner: On the basis of and manner st	n examinati	vledge, death on and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
To th To th		Σ	29b. Signature and the of certifier	Λ	10		29c.	License	number	//-	7	29d. Dat	e signed (Mont	h, Day, Year)
5	K	-	30. Name/and address of person who	completed cause of	death (Item	23a) (Type	Print)	25	1+	4	10	5	102/	2006
	And the second s		KIMPERLEY ANDERSON			OOK ROA		UMBIA	MD 21	.044		1	•	
	State istra		31. Date filed (Month, Day, Year) MAY 0 4 2	32 Registr	ar's Signati	Lire Apr	w/w		· · · · · ·					
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DHMH 17 Rev 1/2001

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UNK UNK		1- For State Registrar	ate aryla		tificate o		and ivier			RegNo	200		12
Physicia Medical Examir	111/	1. Decedent's Name (First, Midd Michael Ju	_{le,Last)} :Stin Hur	lev					Date of De Month May 1, 2	Day	Year	3. Time of Death 1225 hrs	
		4a Facility Name (if not institution	on, give street and no			4b. City, Town	, or Location		,	4	c. County of Dear	th	
Funeral		Civista Medical Cente 5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1	Year If Und	der 24Hrs.	8. Date of E			irthplace (State or	
Director		213-23-9983 Usual Residence of Decedent	1 X M 2 F	27	Yr		Days Hour	rs Min.	Marc	h_3,	1979 ^{Fore}	_{ountry} Marylan	ıd_
v any	Ì	10a. State 10b. County		10c. City,	Town or Loca							10d. Inside City Lin	,
sath with the Maryland items 23a or 28a-f show any ust be notified at once.	į	Maryland Charl 10e Street and Number	es		Waldo	rf T10f. Zip Coc	le		-	10a Cii	tizen of What Cor	1 Yes 2X	No
he Mar 1 or 28;	Director	6341 Porcupine	Court				0603				119		
n with t	Funeral	11. Marital Status	12. Was De	cedent Ever in U.		as Decedent of Yes, specify Cu	Hispanic Or			1 0-		rican Indian, Black,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturan", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	3 Widowed 4 Div	1 Yes	2 🗶 No ar	1	Yes 2 X	No specify	y:				White	
hours "natur		15. Decedent's Education (Spe Elementary/Secondary (0-12)		ade completed)		ent's Usual Occi most of working				16b.	Kind of Business	/Industry	
036 ithin 72 ne. r than	Completed	12			E	lectric	cian				Electr	rical	
215-0 oe filed w ntal Hygie ked othe	Be Co	17. Father's Name (First, Middle William W. Hur						er's Name (F en Mi		, Maider	n Surname)		
D 21 should I ind Mer	P	19a. Informant's Name/Relations		F	785	- ,					City or Town, Stat		ī
and 2 and 2 stealth a treaum	1	William W. Hur 20a Method of Disposition		20b. F	Place of Dispo	sition (Name o	cemetery.	ourt,	<u>Wald</u> Date	20c	MD 2060 Location - City of	13 or Town, State	
more Pages 1 ent of H nt: If		1 X Burial 2 Crematio 4 Donation 5 Other S		I OIII State	crematory or d initv	Memoria	1 Gdns	 s 5-5-	2006	l	Waldorf.	Marvland	
Saltin ermit. I repartm mporta njury o		21. Signature of Funeral Service		0053	22.	Name and Add	ress of Facil	lity	3035	01d	Washing	ton Road	_
Physician	-	23a. Part I. Enter the disease, o	r complications that	caused the death	. Do not enter	ntt Fur	ing, such as	Home cardiac or r	POB 3 espiratory a	156 , arrest, sh	<u>Waldorf</u> nock, or heart	MD 2060 Approximate Inte	rval
/Medical		failure. List only one cause Immediate Cause (Final disease	Advillation to the	juries								Between Onset a Death	and
Administ		or condition resulting in death)	Due to (or as	a consequence o	f):								
	ner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause		a consequence o	f):								
ed isit	Examiner	(Disease or injury that initiated events resulting in death) Last	С	a consequence o	f):								
executed an and al - transit	_	UNPENDED	d. AMENDED										
760, cate be physici	/Med	IF FEMALE: 23b, Was decedent pregnant in	the	, outcome of preg	_				2. 7	23	3d. Date of delive	•	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Medica	past 12 months?	4 Preg	birth gnant at time of de		etal death Other (Specify)	3 Ector	pic pregnan	су		Month	Day Year	
). Bc the dea by the a	Phys	Part II. Other significant cond	a Duki	nown to death but not r	esulting in the	underlying cau	se given in I	Part I.	23e. Dio	tobacco	o use contribute t	o the cause of death?	>
, P.C. ires that signed	d by				_				1 🗌 Y	es 2	✔ No 3 Pro	obably 4 Unknow	νn
ords w requi	Completed									is an opsy formed?	prior to	autopsy findings availa completion of cause	
Rec The la ficate h	Com				. <u>.</u> .			701	1 Yes		No 1 🗸		
/ital /sician:	o Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie		Other		Home 5	Resid	dence 6 Oth	er:	
n of Vital Records, P.C ling Physician: The law requires that After this certificate has been signed funeral director, page 2 should be det	-	27. Manner of Death	28a. Dat (Mon May 1	e of Injury th, Day Year) 2006	28b. Time of		Injury at Wo	In			njury occurred collision		
ision Attencer death rector: by the	Certification:	2 Accident Invi	estigation 28e Pla	ace of Injury - At h					8f. Location	(Street	and Number or F	Rural Route Number,	City
Div oital or ours after eral Diu	ertif	4 Homicide det	uld not be ermined (Specify	Major Roa	d / Highwa	ay		ļ	or Town lawthorne		d at Bibury La	ane, La Plata, M	D
Division of Y To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		(CHECK GIN)	Physician: To the bearing										
To tl withi To tl	Medical	29b. Signature and title of certif	and manner				cense numbe		·		I. Date signed (M		
		1 / Nat	blew	$\mathcal{U}(\mathcal{I})$		0	.C.M.E.			Ma	ay 2, 2006		
107		30. Name and address of person Laron Locke MD.	on who completed ca Assistant Medic			n Street, B	altimore	MD 2120	1				
Nb3	tate			Redistrar's Signat	ure a .	-					.		
Regis		וחוח	4 4 4 4	MITTERS OF THE PARTY OF THE PAR	NS 16	berte							

			For State Registrar	State of	Marylar		artment rtificate			and M	lental Hyg	iene	006	157	30
			1. Decedent's Name (First, Midd	dle, Last)							2. Date of Dear		Vane	3. Time of De	eath
	Physicia /Medic		Howard	С.		Hunt1	.ey				April	25 25	2006	1915	М
	Examin		4a. Facility Name (If not institution	on, give street and numb	er)		4b. City,	Town, or	Location o	of Death		4c. Co	unty of Death	•	
			Anne Arundel	Medical Ce	nter		A	nnap	olis				nne Aru	nde1	
	Funeral Director		5. Social Security Number 067-07-3406	6. Sex 7. 1 XX 4 2□ F	Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, Oct. 21	,1918	9. Birthp Coul New	place (State or F ntry) Jersey	oreign
	w	-	Usual Residence of Decedent 10a. State 10b. Count	N	10c. Cit	ly, Town or Lo	cation				<u>.</u>		1	0d. Inside City I	Limits
	Aaryli Poho	ō		e Arundel		everna								1 🗆 Yes 2	
	28a-i	Director	10e. Street and Number				10f. Zip				1	0g. Citizer	of What Cour	ntry?	
	with Sa or	0	791 Stinchcom	b Road					146				USA	,	
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Department of Heath and Mental Hyglene Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehow any Injury or other traumatic event, Ite Modical Examinar must be notified at ance.	by Funerai	11. Marital Status 1 Never Married 2 Ma 3 X Widowed 4 Divorce	If Yes, Give	es?		Was Deced If Yes, spec		spanic Orion, Mexican	gin? (Spe	ecify Yes or No- Rican, etc.)		Pace - Americ Black, White, pecify: Wh		
ŏ	2 hor	ted	15. Decede	ent's Education		16a. Dece	dent's Usua	I Occupa	ation	t of work	ina	16b. Kind	of Business/In	dustry	
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2	giene giene	TO.		1	,	Pr	inter					U.S.	Govern	ment	
ם	al Hy d oth	Be (17. Father's Name (First, Middle	a, Last)					18. Mothe	er's Name	e (First, Middle, I	Maiden Su	mame)		
<u>yla</u>	Ment Ment mrke atic	횬	Howard B. Hun	tley					Lo	ouis	e Cordes				
Maryland	and and is my	- 3/	19a. Informant's Name/Relation								al Route Number				
	end ealth m 27		Howard Huntle	y (Son)	201	-					everna P				
Ore	t of H If Ite or oth		20a. Method of Disposition **Burial 2	n 3 □Removal from St	ate	Place of Dispo cemetery, cres			1				ion - City or To		
Ë	Pag tment tant:		4 Donation 5 Other	(Specify)		5-1-2			n Grove	, NJ					
Baltimore,	permit Depar Impor any In		21. Signature of Funeral Service	e Licerisale		22	Hard 12 R	esty idge	Fune 1y Av	enue	Home, P e, Annap	.A. olis	MD 21	401	
	Physician		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	or complications that cause on each	sed the deat	th. Do no ent	er the mode	of dying	g, such as	cardiac o	or respiratory arr	est,		Approximate Interval Betwee Onset and Dea	
	medical Examined be executed by bhysicien and burial-transit site burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (as a consection as a consection	Vola	rep	Her yrl	art	for	lun ESY	eno	sis	710 year	7
8760,	ate be hysicie the bur	cai		d											
.O. Box 68	The law requires that the death certifica sie hes been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Feta nt at time of c	ul death 3 [Ectopic pro					230	Date of delive	ery Day Yea	àr
<u> </u>	w requires that been signed b should be deta	ed by PI	Part II. Other significant condi	tions contributing to dea	th but not res	sulting in the u	nderlying ca	ause give	en in Part I.			oacco use es 2□N		ne cause of deat	
Vital Records,		Completed									24a. Was a autops perform	v		psy findings ava mpletion of caus 2 No	
Vita	siclan: Th certificete irector, pag	Be	25. Was case referred to medic examiner?	Hospital:	-			- Oth-		of Death	(Check only on	e)			
ð	2 w =	٩	1 Yes 2 No	28a. Date of		ER/Outpatier 28b. Time o			4 🗆 140		me 5 Reside			y)	
u C	Jing After fune	io u	1 Naturat 5 Pend	ding (Month,	Day Year)	Injury	M	8c. Injury Work	rat c? Yes 2 □ I		28d. Describe ho	w injury o	ccurred		
Division	Attending r death. ector: After by the funer	ficat	3 ☐ Suicide 6 ☐ Coul	mined 28e. Place o	f Injury - At h	ome, farm, str			162 2 🗆 1		28f. Location (St	reet and N	lumber or Rura	I Route Number	r,
ă	ital or irs efter ral Dire	Certification:	4 nomicide	Building	, etc. (Speci						City or Town				
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	ledicai	(Check only 2 Medica	ring Physician: To the bas all Examiner: On the bas and manne	is of examina	wladga deat ation and/or in	vestigation,	in my of	oinion, dea	d placu th occurr	ed at the time, d	ate and pla	ace, and due to	the cause(s)	
	Mith To	₹	29b. Signature and title of certif) Obe	An	M		0	714	(38		Agn	igned (Month,	T, 200	06
			MICHAEL J.	completed cause	of death (Iter	1 DE	Print)	EH	igH	NAy	Anni	APOLI,	Mon	1401	
	Sta Registi		31. Date filed (Month, Day, Yea MAY 0 3	200b 32. Reg	gistrar's Signa	ature									

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 12:35 P M **Physician** April 19. Temple Weaver Hays /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fairhaven Retirement Community Svkesville Carrol1 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 101/10/1925) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2√√ F Vrs Oklahoma 81 579-30-9896 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County id other then "natural", or Items 23e or 28e-f ehow event, the Medical Examiner must be notified at 1 Yes XXXIII Carrol1 Finksburg Maryland Maryland Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 21048 3354 Niner Road LISA Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after 1 ☐ Yes 2XXNo 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: If Yes, Give Year or Dates: þ 3x√xVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then College (1-4or 5+) Elementary/Secondary (0-12) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be to nent of Health and Mental I snt: If item 27 Is marked of Orville Gibson Weaver Lorein Fender other treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean Walker / Daughter 3354 Niner Road Finksburg, Maryland 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If its any injury or ot 1 DBurial 2 Cremation 3 Removal from State April 26, 2006 Cheltenham, Maryland Maryland Vet. Cemetery 1 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service License 22. Name and Address of Facility once. George P. Kalas Funeral Home P.A. alle 11 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part P. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death 2 MOS. Immediate Cause (Final disease or condition Carcinoma of Pancreas Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attanding Physicien: The law requires that the death certificate be executed burial-transit Exam and Due to (or as a consequence of) Box 68760, physician Physician/Medical attending | SS IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 ormed? certificate 1 Yes Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2KKNo 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After XX Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeref Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D32882 May 11, 2006 Z. Mon 30. Name and address of person process of completed cause of death (Item 23a) (Type, Print) 114 Business Center Drive Reisterstown, Maryland 21132 Robert L. Moss 31. Date filed (Month, Day, Year) State MAY 1 5 2006 Registrar

			1 = For State Registrar	State of Mary	•	artmen rtificat			nd Me		giene Reg. No	ZUUb	15732
	1 10		1. Decedent's Name (First, Middle, Last)							2. Date of Dea		y Year	3. Time of Death
	Physici Medic/		Dalvin Hebron							April :	29,	2006	9:40 p M
)	Examin		4a. Facility Name (If not institution, give s	reet and number)				Location of	Death			. County of Death	
			39 Keepsake Place			Wald						Charles (
	Funeral		5. Social Security Number 6. Sex	14 0 7 5	yrs. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day July 2.	h K <i>Year</i>	9. Birth Cou	place (State or Foreign intry)
	Director		214-28-9074 X Usual Residence of Decedent	M 2 F 73) 113.					July 2.	3, 1	1932 Mary	yrand
	land		10a. State 10b. County	100	c. City, Town or Lo	ocation							10d. Inside City Limits
	Many	ŏ	Maryland Charles		Waldorf								1√2 Yes 2 No
	1 the	Je C	10e. Street and Number			10f. Zip	Code				10g. Ci	tizen of What Cou	intry?
	h with	<u>_</u>	39 Keepsake Place			20	0602				Uni	ited Stat	tes
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or lems 23a or 28a-f show ont, the Mydical Exam, are must be redified at	Completed by Funeral Director	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Dece	dent of His	spanic Orig	in? (Spec	offy Yes or No-		14. Race - Amer Black, White	
9	or Ite	교	1 ☐ Never Married 2 ☐ Married	1XTYes 2 No		1 ☐ Yes		Specify:					
8	ural',	d b	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:								Specify: Blac	
7	nat roce	lete	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usua kind of wo	al Occupa	ition u <i>ring</i> most)	of workin	g	16b. K	and of Business/In	ndustry
12	withir ene. then	Ē	Elementary/Secondary (0-12) 9th	College (1-4or 5+)		Fitt		,			Gos	rernment	
9	Hygi Hygi other		17. Father's Name (First, Middle, Last)		1 1 1 1			18. Mother	r's Name	(First, Middle,			
an	id be ental ked c	To Be	Robert Hebron					Meli	nda	Payne	e		
Maryland 21215-0036	2 should be and Mental le marked o	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Address	(Street a	nd Number	r or Rural	Route Numbe	r, City	or Town, State, Zi	p Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If Item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Mydical Examinar must be notified at		Melinda Hebron /	Daughter	39 K	Ceepsa	ake P	lace	Wald	orf, Ma	ary1	land 2060	02
ore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		Ob. Place of Dispo	osition (Nar	ne of other place	9)	Da	ate	20c. L	ocation - City or T	own, State
Ĕ	nit. Peges eartment of t ortant: If its injury or o		4 □ Donation 5 □ Other (Specify)	I I	t. Linco	1n Ce	emete	ry 5	5/5/2	006	Bre	entwood,	Maryland
Baltimore,	permit. Pege Depertment of Important: If any injury or once.		21. Signature of Fun and Service Licen	1/ 1	/ 2	Texaf	d Addres	sof Facility	pe F	uneral	Hon	nes, P.A.	•
_	70 F # 9		well s.	Helle								le, Mary	land 20747
1	Prrysician /Medical Examiner		23a. Part. Ether the disease, or complic shock, for heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a co	HEIN	∧£√.	-			espiratory ar	_		Approximate Interval Between Onset and Death
8760,	death certificate be executed eattending physicien and of for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co									
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.O. Box	it the death certific. by the attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3[⊒Ectopic pi ⊒ Other (sp						23d. Date of deliv Month	very Day Year
rds, P.	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	ributing to death but no	ot resulting in the u	nderlying o	ause give	n in Part I.			bacco es 2		the cause of death?
of Vital Records,		Completed							_	24a. Was autop perfor 1 Yes	sy	prior to co	opsy findings available ompletion of cause of 2 No
Z.	Physician: T this certificer ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:			Othe			Check only or			
oţ	Phys r this ral dir	7	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatier		JA	4 🗀 19Ur	sing Hom	e 5 Resid		6 Other (Speci	fy)
o	ding h. h. After funer	tion	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ar) Injury	м	28c. Injury Work	? ′es 2 ⊟N		od. Dodonbo n	010 11110	ry occurred	
Division	To the Hospital or Atlanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, sti pecify)					8f. Location (S City or Tow	îtreet ar n, State	nd Number or Aur e)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in 1	Medicai (29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of mar: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, death	place, ar	nd due to the o	ause(s late and) and manner as s d place, and due t	stated. o the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier			290	. License	number		1	29d. Da	te signed (Month,	Day, Year)
^	(0)		pour T	Mouth	-	n	Pri	35	1			81/09	106
K	(5)		30. Name and address of person who col	x 2-	129	Print)	Pla	este		cm	2	0640	5
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 1 2006	Registrar's	Signature	de .							4

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name /First Middle Last Day Month Year **Physician** 9:40am M 24, Bertha P. Joyner-Warren 2006 April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6906 Westchester DR. Prince George Temple Hills If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov. 29, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 1 F 96 1909 South CArolina 578-48-0736 **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-1 show the Medical Examiner must be notified at 1√ Yes 2 No Maryland Prince George Temple Hills Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6906 Westchester Dr. 20748 United States "naturel", or items 23e death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Nurse Medical is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked ofth any intry or other treumatic event, 2008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harvey Peterson Dora Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harvey A. Joyner/Son 6906 Westchester Dr., Temple Hills, Md. 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 04/29/2006 Suitland, MD. * 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licens complications that caused the deat onty one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition resulting in death) Metastatic Colon Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE esn 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Dav Year ō 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1 ☐ Yes 2 🛣 No the Hospitel or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) 2 after death.

I Director: After this d in by the funeral d 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2. To the I Atier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title DC 12080 28,2006 30. Name and address of person who completed cause of death (Ite., 23a) (Type, Print) Marc Shepard, M.D. 2021 K Street, NW. #310; Washington, D.C. 20036 31. Date filed (Month, D Registrar's Signature Day, Year) 2006 State Registrar

		1- State of Maryland / Department of Health Certificate of Death	3	giene Reg. No. 2006	15734
		Decedent's Name (First, Middle, Last)	2. Date of De	ath Day Year	3. Time of Death
Physi /Med	ician dical	Loretta Young Jackson		27, 2006	5:54 p M
Exam		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location	of Death	4c. County of Death	
		Prince Georges Hospital Cheverly		Prince Ge	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	y, Year) Cour	place (State or Foreign	
Directo	or	578-42-7001 Usual Residence of Decedent	Sept. 2	6, 1933WAsh	ington,D.C.
land		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
Many -f sh	ğ	Maryland Prince Georges Largo			1X Yes 2 □ No
the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cour	ntry?
3a o		348 Harry S. Truman Dr. 20774		United Stat	es
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	origin? (Specify Yes or No	- 14. Race - Americ	
after or ite	豆	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify		Black, White, Specify: Blac	
ours rai',	d by	3 🖾 Widowed 4 □ Divorced Year or Dates:	······································		
nati	Completed	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most life. DO NOT use retired)	st of working	16b. Kind of Business/In	dustry
than	g E	Elementary/Secondary (0-12) College (1-4or 5+)		Modran 1	
Hygie ther	ပိ	2 Practical Nurse 17. Father's Name (First, Middle, Last) 18. Moth	ner's Name (First, Middle,	Medical Maiden Sumame)	
d be antal	o Be		thryn Day		
2 should be filed within 72 hours after death with the Maryland Sahould Mental Hygjone is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinar must be notified at	5	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street</i> and <i>Numb</i>		er, City or Town, State, Zip	Code)
nd 2 alth a 27 is		Jerome Jackson / Son 1208 Teresa Dr. Acc	cokeek, Md.	20607	
item item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or To	own, State
Page nent ant: if		1 & Burial 2 Uremation 3 Linemoval from State	May 6,2006	Laurel, Md.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inportant: of Health Mantal Hygiene. In important: if them 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at	- BOCO	21. Signatur of Funeral Service Licenses 22. Name and Address of Facil Alexander S. I 5538 Marlboro	Pope Funeral Pike/Forest	Homes,P.A.	20747
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition FATAL (ARDIAC ARRHY	THMIA		Onset and Death
/Medica	al	resulting in death) Due to (or as a consequence of):			
Examine	er	Sequentially list conditions b.			
P in	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
ecute and -trans	kam	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
cate be executed oblysician and the burial-transit		Sub-to-(of as a consequence of).			
phys s the	dicai	d			
leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delive	irv
d for	clar	in the past 12 months? 1 Ves 2 N No. 1 Ves 2 N No.		Month	Day Year
requires that the de been signed by the should be detached	hys	9 Unknown			
s tha	by P	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part	I. 23e. Did to	bacco use contribute to the	e cause of death?
aquire en sig			1 🗆 Y	fes 2□No 3□Prob	abiy 4 AUnknown
law re as be 2 sho	Completed		24a. Was		psy findings available inpletion of cause of
ysician: The law is certificate has t director, page 2 s	ĕ		perfo	rmed? death? 2 No 1 □ Yes	
clan: ertific	Be (examiner?	ce of Death (Check only o	ne)	
hysi this c	은			dence 6 Other (Specific	1)
Attending Ph or death. ector: After th by the funeral	lon	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 1 Natural investigation M 1 Yes 2		now injury occurred	
death ctor:	icat	3 Suicide 6 Could not be 380 Blace of Injury. At home form street feetons office	-	Street and Number or Rura	l Route Number
i or A after Dire	Certification;	4 Homicide determined building, etc. (Specify)	City or Tox		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
spita nours norai		29a. Certifier iZ Certifying Physician: To the best of my knowledge, death occurred at the time, date as	and place, and due to the	cause(s) and manner as si	ated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, decay and manney stated.	ath occurred at the time,	date and place, and due to	the cause(s)
Withi To t	Σ	29b. Signature and title of certifier 29c. License number	~	29d. Date signed (Month,	
5		Volument Descent Descon	677	5-2-	06
Rj		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WENDELL HERSON, MI) 30. On the state of the stat	DR C	5-2- HEVERLY M	0 20185
Regi	State strar	31. Date filed (Month, Day, Year) MAY 0 4 2006 32. Registrar's Signature			

			For State Registrar	State of Maryland /	Department of He Certificate of D	eath	Reg. No.		15735
0.	Physici /Medic		1. Decedent's Name (First, Middle, Last Blanche H	Keech		2	Date of Death Month Day	y Year 2000	3. Time of Death
¥.	Examin		4a. Facility Name (If not institution, give Bradferd acula NS9	street and number) Alehab	Clinter	am ic		. County of Death	
x ^c	Funeral Director		5. Social Security Number 6. \$ 002-05-1983 Usual Residence of Decedent	7. Age (In yrs. last b		If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year) 2-15-191	9. Birthp Coun CAN	
	the Maryland 28a-f ehow	'n	10a. State 10b. County MARYLAND PRINCE		m or Location LINTON			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	rect	10e. Street and Number	diokol 5 c	10f. Zip Code		10g. Citi	izen of What Coun	
	23a or	alD	7520 SURRATTS F	ROAD	20	735	J	U.S.A.	
36	after des or items	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	panic Origin? (Speci Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, of Specify: WH	
215-0036	ithin 72 hours nan "natural", nan "matural",	Completed	15. Decedent's E. (Specify only highest gra	ucation de completed) 168 College (1-4or 5+)	a. Decedent's Usual Occupati (Give kind of work done dui life. DO NOT use retired)	on ring most of working	16b. Ki	ind of Business/Inc	
121	should be filed within a Mental Hygiene. marked other than mattic event, the Mental than the Mental count.		17. Father's Name (First, Middle, Last)		HOMEMAKER	8 Mother's Name //	First, Middle, Maiden	NN HOME	<u> </u>
Maryland	ould be f Mental I arked of	To Be	JOSEPH LACASSE		'		TTE BOUC	,	
ary	and Men ie marke	-	19a. Informant's Name/Relationship (b. Mailing Address (Street and				Code)
	1 and 2 Health a em 27 is		NONA HEILMEIEF						
Baltimore	m O		20a. Method of Disposition Maria 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State cemeter ST.MARY		M. 5-15-		JASCO, MA	
Bal	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service Licer 23a. Part1. Enter-the disease, or com			FUNERAL	SERVICE		
	Physician /Medical Examiner		23a. Part. Enter-the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	school o	Such as cardiac or r		1/46913	Approximate Interval Between Onset and Death
A.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence	o of):				
8760,	certificate be executed ading physicien and use as the burial-transit		resulting in death) Last	Due to (or as a consequence	9 of):				
.O. Box 6	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ☐ No- 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	ires sign d be	by	Part il. Dther significant conditions of	ontributing to death but not resulting	in the underlying cause given	in Part I.	23e. Did tobacco u 1 ☐ Yes 2∫	£	
Records,	The law ate has b page 2 si	Completed					24a. Was an autopsy performed	prior to con death?	psy findings available inpletion of cause of 2 No
Vital	ician: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (6	Check only one)		
of	Physician: this certific ral director,	. To	1 Yes 2 Yo	Hospital: 1 Inpatient 2 ER/O			5 Residence 6		<u> </u>
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Surcide 6 Could not b	(Month, Day Year)	Injury Work? M 1 ☐ Ye	s 2 No	Location (Street and		/ Courte Mumber
Div	pitel or A urs after arel Direc		4 Homicide determined	building, etc. (Specify)			City or Town, State)	
	Hospitei 24 hours 2 Funerel stely filled	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Example 1	ysician: To the best of my knowledg niner: On the basis of examination a and manner stated.	ge, death occurred at the time, ind/or investigation, in my opin	, date and place, and nion, death occurred	due to the cause(s) at the time, date and	and manner as sta i place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of extitier		29c. Lisense r	743)	29d. Date	te signed (Month, L	Day, Year)
	10		30. Name and address of person who	completed cause of death (Item 23a)	(Type, Print) Newgraw	Ad \$105	A.V.	sho ghou	MD 2574
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	cons		,	V	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 14, MAY 2006 11:01 A.M KROM MARY ALICE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK EMMITSBURG ST. CATHERINE'S NURSING CENTER 8. Date of Birth (Month, Day, Year) NOV. 8,1914 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Min 1 ☐ M 2 🛛 F Months Days Hours MARYLAND 91 213-01-3796 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 TYes 2X No FREDERICK **EMMITSBURG** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21727 U.S.A. 17213 NOUNTAIN VIEW RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PANTS FACTORY SEAMSTRESS 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) RUTH RIFFLE **EDWARD** JOHN SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16731 ANNANDALE RD., EMMITSBURG, MD. 21727 PHILIP W. KROM/ SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 5/17/2006 EMMITSBURG, MD. 21727 EMMITSBURG MEMORIAL * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME EMMITSBURG, MD. 21727 210 W. MAIN ST., Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 AL 100 Due to (or as a consquence of): Sequentially list conditions, in y leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 2 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

423a r

"natural", or items

than

other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg important: if item 27 is marked other any injury or other traumatic event, i

filed within 72 h I Hygiene.

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

MD

with the Maryland

Baltimore, Maryland 21215-0036

the attending physician and hed for use as the burial-transit The taw requires that the death certificate be executed signed by certificate has been signe irector, page 2 should be or Attending Physician: funeral dir

P.O. Box 68760

Division of Vital Records,

Examiner Physician/Medical þ Completed 25. Was case referred to medical Be Certification: To 27. Manner of Death

IF FEMALE 23b. Was decedent pregnant in the past 12 months?

examiner?

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Yes 2 No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

autopsy performed?

1 Yes 2 No Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No

26. Place of Death (Check only one) Other: 4 X Nursing Home

3 DOA 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) Injun 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

12

29d. Date signed (Month, Day, Year)

1ain

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MPEL-BONITA Par

Hospital: 1 Inpatient

31. Date filed (Month, Day, Year)

MAY 1 8 2006

5 Pending

investigation 6 Could not be determined



within 24 hours after death. To the Funeral Director: A

To the Hospital

filled in by

10

State

Registrar

Medical

			For State Registrar	State	of Mary	•	artment of rtificate of		and Menta	, ,	ene	5	15737	
- a			1. Decedent's Name (First, Middle	e, Last)	-				2. Date Mon	of Death	Day	Year	3. Time of Death	
	nysicia Medic			W. Kend					May	14,	2006		6:45 A. M	
- * E	xamin	er	4a. Facility Name (If not institution	n, give street and n	iumber)		4b. City, Town,				4c. County o			
	14.0		Homewood 5. Social Security Number	6. Sex	7 Age (In	yrs. last birthday		liams		of Birth			ngton place (State or Foreign	
	neral ector		220-34-0217	1□M 2 X F	67	Yrs.	Months Day		Min. (Mor	th, Day, Y	(ear)	Cou	sylvania	
g g			Usual Residence of Decedent											
anyla	ia la	7	10a. State 10b. County		100	c. City, Town or L	_						10d. Inside City Limits 1 ☐ Yes 2X No	
the M	affilia	ecto	Md. Was	hington		Boon	sboro			100	g. Citizen of W	nat Cou		
death with the Maryland	4	ā	8023 Old Natio	nal Pike			101. E.p 0000	217	13	.0		J.S.	•	
death	eumatic event, the Madical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was De	cedent Ever	in U.S. 13.	Was Decedent of	Hispanic Or	rigin? (Specify Yes In, Puerto Rican, e	s or No-	14. Race	- Ameri	can Indian,	
ct 21215-0036 filed within 72 hours after Hygiene.	uchus	y Fu	1 Never Married X Marr	ned 1 ☐ Yes If Yes, (i 2∭ No Give		1 ☐ Yes 2 XN			1.0.)	Specify:	White,	White	
DO Sinou	al Ex	ed by	3 Widowed 4 Divorced	Year or	Dates:	16a Dans				14/		· d -		
in 72	albal	Completed	(Specify only highes	st grade completed		(Give	dent's Usual Occi kind of work don DO NOT use retii	e durina mos	st of working	16	Sb. Kind of Bus		•	
d with	ad .	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		Nurse				Nursin	g H	ome	
be file	vent,	BeC	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name (First, I	Middle, Ma	aiden Sumame)		
aryla should t	atic	2	William E		irk				Mabel (
Maryland 21215-0036 nd 2 should be filed within 72 hours af and Mental Hygiens, "series" or	or other treumatic		19a. Informant's Name/Relations Owen Leon Kendl				-		ner or Rural Route					
	ther		20a. Method of Disposition	e (nusbai	· · · · · · · · · · · · · · · · · · ·	Ob. Place of Disp	osition (Name of		Pike Boo		ro, Ma. Oc. Location - C			
Pages	y or c	i	1 Donation 5 Other (S		m State	cemetery, cre Smithsbu	matory or other pi rq Crema		May 16, 2006		mithsbu	1		
Baltimore, permit. Pages 1 at Department of Hea	any injury o		21. Signature of Funeral Service				2. Name and Add		THE RESERVE TO AND		25 Brad			
n aa	. a		To Pro	e DAV	is M	01414 J	.L. Davi	s Fune	eral Home		thsburg			
36 36	7		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the	death. Do not en	ter the mode of dy	ing, such as	s cardiac or respira	atory arres	it,		Approximate Interval Between	
Phys	4		Immediate Cause (Final Death Onset and Death Onset and Death											
/Me Exan	dical niner	resulting in death) a. Due to (or as a consequence of):									. 0		1994	
* * ·	₹ *-	e	Sequentially list conditions, if any, leading to immediate	b. — Due t	o (or as a co	nsequence of):		· · ·	NICE /S	1714		-		
pen ,	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S										
0, 9 exec	rial-tr		resulting in death) Last	Due t	o (or as a co	nsequence of):								
Records, P.O. Box 68760, The law requires that the death certificate be executed	the burial-transit	dical		d						····				
OX 6 h certific	for use as t	/Me	IF FEMALE:	23c. If yes, c	outcome of p	regnancy					004.0-4-	-4 d-E		
Bo Bath c	for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	p birth 2 [Fetal death 3	□Ectopic pregnan □ Other (specify)	су			23d. Date Mont		ery Day Year	
O. 8	detached	hysl	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Uni										
S that	should be det	oy P	Part II. Other significant condition	ons contributing to	death but no	ot resulting in the t	underlying cause o	jiven in Part	I. 23e	. Did toba	cco use contrib	ute to t	he cause of death?	
ord:	onidit									1 🗆 Yes	2 □ No 3	Prot	pably 4 Vinknown	
Records,	2 (3	Completed							248	. Was an autopsy	24b. W	ere auto	psy findings available mpletion of cause of	
	director, page								1 🗆	performe Yes 2	ed // de	ath?	2 🗆 No	
Vital	rector, pag	Be c	25. Was case referred to medica examiner? 1 1 Yes 2 No	Hospital:	76	a∏50/0 · ·		/	e of Death Check	-				
Phy of	- ro	n: To	1 □ Yes 2 No 27. Manyrer of Death		fnpatient te of Injury onth, Day Ye	2 ER/Outpatie	nt 3 DOA	4 LA N	ursing Home 5 [ce 6 ∐Other rinjury occurre		(y)	
Division of lor Attending Phy after death.	e fun	atloi	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	'9	onth, Day Ye	ar) Injury		ork? ⊒Yes 2.⊑]No					
IVIS	by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Fld	ce of Injury - Iding, etc. (S	At home, farm, st	reet, factory, offic	9		ation (Stre		or Aura	al Route Number,	
Oltal o	led in													
Hosp 24 ho	stely fi	Medical	29a. Certifier (Check only one)	ng Physician: To t Examinar: On the	he best of m basis of exa anner stated.	y knowledge, dea amination and/or ir	th occurred at the nvestigation, in my	time, date ai opinion, dea	nd place, and due ath occurred at the	to the cau time, date	ise(s) and man e and place, ar	ner as s id due to	tated. o the cause(s)	
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death	completely filled in by the fune	Me	29b. Signature (Carding) certifie		ALTIO STATEU.	X	29c. L ice	nse number		290	d. Date signed	Month,	Day, Year)	
F 51	- 0		DIAY/18	11/16	DICIA	Dace	The I	170	857		5/15	12	006	
	6		30. Name and address browson	who completed ca	use of death	(Item 23a) (Type	Print)	1	0	, 11	3/1	1	11.1	
	Т		(TEPHEN C-M	ETENIA	, UnC) [3	424 Kg	-ALE)) TE 10	1 /14	te custo	KUL	106	
F	Sta legistr		31. Date filed (Month, Day, Year)	2006	Registrar's	Signature	The state of the s	,				•	1	

			For		ryland / Depa	artment	of Health and	•		Legible.	15720
			1 - State Registrar		Ce	rtificate	of Death		Reg. No.	OUU.	10100
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Stephan Kuryla					2. Date of De Month May 2	Day	Year 06	3. Time of Death 9:52 P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of Deat		-	County of Death	1 7.52 1
			1807 Blueridge A	venue		Silv	er Spring			Montgom	erv
	Funeral		5. Social Security Number 6. Sec.		(In yrs. last birthday)	If Under 1			h		olace (State or Foreign
	Director		148 26 //06	7M 2UF	85 Yrs.		110013	Feb. 6			aine
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation					I Od. Inside City Limits
	Maryl feb	5									1 ☐ Yes 2X No
	death with the Maryland ime 23a or 28e-f ehow frolust be codified at	Director	Maryland Montgome:	ry	Silver Sp	10f. Zip C	ode		10g Citiz	en of What Cour	ntry?
	3a or	<u></u>	1807 Blueridge Av	eniie			20902			USA	,.
	me 2	Funeral		12. Was Decedent E	ver in U.S. 13.		nt of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No	. 1	4. Race - Amend	an Indian.
Maryland 21215-0036	be filed within 72 hours after death with the Marylan stal Hygiene. Id other then "natural", or iteme 23a or 28e-f ehow other then "natural", or iteme 23a or 28e-f ehow event, the Medical Extraction on the filed at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	fYes, specify 1 ☐ Yes 🙎		to Rican, etc.)		Black, White, Specify: White	etc.
Ö	2 ho	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual (Occupation		16b. Kin	d of Business/Inc	dustry
3	within 7 ene. then "r	pie	(Specify only highest grade Efementary/Secondary (0-12)	Colfege (1-4or 5-	life !	DO NOT use	done during most of wor retired)	rking			,
21	e filed within al Hygiene. other then ' vent, the We	5		5+		terina	rian		US G	overnmen	nt USDA
<u>p</u>	be filed tal Hygi d other event, t	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden S	Sumame)	
<u>Va</u>	should be nd Mental marked umatic ev	ဥ	Wasyl Kurylas				Olenka K	orduba			
a	and and iem	0 9	19a. Informant's Name/Relationship (Ty)	_			itreet and Number or Ru				
2	and ealth m 27		Olha Kurylas / Wit	fe ————			idge Avenue		Spri	ng, MD	20902
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: if item 27 ie marked eny injury or other treumatic e once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □R	emoval from State	20b. Place of Dispo cemetery, cren	sition (Name natory or othe	of or place)	Date	20c. Loc	ation - City or To	wn, State
Ë	Fant:		4 ☐ Donation 5 ☐ Other (Specify)		Cedar Hi			/06		land, Ma	
3al	ermit lepar npor ny in		21. Signature of Funeral Service License	98			Address of Facilit Hin				
_	00 F • 0		roquant	ceura			ew Hampshir			Spring	,MD 20904
	Provided at the provided American and American and Provided transit tr	Examiner	23å Part 1. Enter the disease, or complishock, of heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate name fitter in deriving Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a	consequence of): arcinoma, inconsequence of): consequence of):	ıre					Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be sie has been signed by the ettending physicia page 2 should be detached for use as the but	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	I. 3c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregi Other (speci			23	3d. Date of delive Month	ry Day Year
ر. ص	res tha signed be det	γP	Part II. Other significant conditions con	tributing to death bul	not resulting in the ur	derlying caus	se given in Part I.	23e. Did to	bacco use	e contribute to th	e cause of death?
Vital Records,	w require been sig should b	edt	<u>Type II Diabetes</u>					1 □ Y	es 2 🗆	No 3⊠ Proba	ably 4 \ Unknown
ပ္သ	s bee	Completed						24a. Wasa	ın	24b. Were autor	osy findings available
æ	The i	E						autop	med?	prior to con death?	npletion of cause of
ā	en: tiffice tor. p	Bec	25. Was case referred to medical		5.46	-	26 Place of Dea	1 ☐ Yes	3₹¥No	1 🗆 Yes	2 LI NO
	Physicien: r this certific ral director,	To B	examiner?	ospital: 1 🗆 Inpatien	t 2 ER/Outpatien	3 DOA	0.1	ome 5 Resid		Other (Specify	.)
0	ig Ph ter th	<u></u>	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of		fnjury at Work?	28d. Describe h			<u></u>
<u>ō</u>	Attending r death.	atio	12⊡Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month), Day	Year) Infury	м	1 ☐ Yes 2 ☐ No				
É	s after de bi Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y · At home, farm, stre (Specify)	eet, factory, of	fice	28f. Location (S City or Tow	treet and in, State)	Number or Rural	Route Number,
	To the Hospital or Attending Physicien: The lav within E Aurous after death. Within E Aurous after death. Yo the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier 1 Certifying Phys	ician: To the best of ner: On the basis of a and manner state	examination and/or inv	occurrad at t estigation, in	he time, date and place, my opinion, death occur	, and due to the c rred at the time, d	ause(s) ar ate and p	nd manner as sta lace, and due to	ited. the cause(s)
	To 1 To 1	Σ	29b. Signatural and title of dentrier	000			cense number			signed (Month, E	ay, Year)
•			I WULL HA			H	45839		May	3, 2006	
	>		30. Name and address of person who con	mpfeted cause of dea	ath (ftem 23a) (Type, I	Print)					
			Gary E. Raffel,M.			Lane #:	202A Bethes	da, Mary	1and	20814	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4 2006	32. Registrar	's Signature	W					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year FAINA 2006 KUBLANOVA MAY 1, 11:20 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 M 2 KF Director 216-33-9036 RUSSIA 12/12/1914 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene, ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow usy or other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND MONTGOMERY SILVER SPRING Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3607 PEARTREE COURT, APT. 14 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after d il Hygiene. other than "natural", or Item Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> 3 → Widowed 4 □ Divorced Specify: Year or Dates: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ STAROBINSKY BELLA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 2ND AVENUE, PORT JEFFERSON, NEW YORK 11777 MICHAEL SCHWARTZ/GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: If its
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 05/02/2006 OLNEY, MARYLAND 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses Zudewa anda 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner MULTIPLE ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ADHESIONS and burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical 88 IF FEMALE: esn 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? , page 2 certificate Division of Vital 1 Yes 2 🛛 No 1 Tyes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the north after death.

To the Funeral Director: Aft Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, 3 lame and address of person who completed cause of death (Item 23a) (Type, Print) 3416 Olandwood Wood 31. Date filed (Month, Day, Year) egistrar's Signature State 32 MAY 04 2006 Registrar

6.5	4.5		1 - For State Registray/FND#23a(b)pc	State of Ma	-	0-		nt of H te of L		and M		jiene	006	15740
	Physici /Medic	al	1. Decedent's Name (First, Middle, L I . Kwang	Kim	********					/ D - 15	2. Date of Dea April	28°,	200 ^Y 6 ^{ar}	3. Time of Death 5:38p м
	Examin	er	4a. Facility Name (If not institution, graces Gasey House) 5 Social Security Number 6	е	e /in vrs	last birthday)	R	or 1 Year	ille		8 Date of Birth	Mo	ounty of Death	mery
	Funeral Director		5. Social Security Number 438-11-7983 Usual Residence of Decedent	1 XM 2 F	83	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day 1 / 0 3 /	1923	Kor	nplace (State or Foreign untry) ea
	Maryland 8-f ehow liled at	tor	MD 10b. County MD Montgo	omery		y. Town or Lo		ing						10d. Inside City Limits 1 Yes X No
	th with the 23e or 28	Funeral Director	10e. Street and Number 531 Randolph	Road #31	5B		10f. Z	ip Code 209	04				n of What Col	untry?
980	n 72 hours atter death with the Maryland "natural", or items 23e or 28s-f ehow pical Examination must be notified at	<u>م</u>	11. Marital Status 1 ☐ Never Married 2 ☆ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:		1	_	edent of Hi ecify Cuba 200 No	ispanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	city Yes or No- Rican, etc.)		Race - Amer Black, White pecify:	
Maryland 21215-0036	within 72 ene. then "na	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or t	5+)	life.	kind of w	ork done d use retired	during most	of workii	ng		of Business/I	
yland 2	iould be filed I Mental Hygi varked other vatic event, II	To Be C	17. Father's Name (First, Middle, Las Cha Chi Kim	t)							(First, Middle, In Yim	Maiden Su	итате)	
	es 1 and 2 should b of Health and Ment fitem 27 ie marked r other treumatic e		19a. Informant's Name/Relationship Christopher Ki		-	740	5 0	tten		k Te		Der	wood,	Md20855
Baltimore,	permit. Pages 1 Depertment of He important: if ther any injury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Contro		C	lace of Dispo emetery, crer late C	natory or	other plac	n 5	/01/	⁴ 06		tion · City or]	own, State pring, Md
Balt	permit. Depertimport eny inj		21. Signature Fineral Service Lic	will	-1						FUNERA d.Sil			E,P.A. g,Md20910
	Pnysician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused y one cause on each li aACUTE Due to (or as	ne. Res	pirat					r respiratory arr	est,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Chroni Due to (or as	c Obs	struct.	ive 1	Pulmo	nary	Dise	ase			
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O. Box 68	death certific a attending p od for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3□	Ectopic Other (s	oregnancy specify)				230	d. Date of delin	very Day Year
<u> </u>	ires the signed d be de	þ	Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	nderlying	cause give	en in Part I.			bacco use		the cause of death?
al Records,	: The law requicate has been ; paga 2 should	Completed									24a. Was a autops perform	med?	prior to c death?	opsy findings available ompletion of cause of
f Vital	Physician: Th ribis certiticate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2	ER/Outpatier	it 3 🗆 C	Othe Othe			(Check only or ne 5 ☐ Reside		Other (Spec	whospice
ion of	20 00 00		27. Manner of Death 1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigati		y Year)	28b. Time of Injury	м	28c. Injury Work		2	8d. Describe h			
Division	- 0 -	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At ho c. <i>(Specif</i>)	ome, farm, str	eet, facto	ry, office		2	8f. Location (S City or Town		Number or Rui	ral Route Number,
	To the Hospital of within 24 hours et To the Funerel D completely tilled in	Medical	29a. Certifier 1 Certifying F (Check only 2 Medical Ex-	Physician: To the best aminer: On the basis of and manner st	f examina	wledge, death tion and/or in	occurre vestigation	d at the tim n, in my op	ne, date and pinion, deat	d place, a th occurre	nd due to the c ed at the time, d	ause(s) an ate and pl	nd manner as ace, and due	stated. to the cause(s)
	To within	Σ	29b. Signature and title of celtifier		/	MD	2	D365			2		igned (Month	
	1,		30. Name and address of person was Seph Kaplan					Mill	Roa	d Ro	ockvil	le,Mc	2085	5
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registr	ar's Signa	ture do	ule	S.						

			For State Registrar	State	of Marylar	•	artment of		nd Mer		iene eg. No.	200	5 1	5	741
	.		1. Decedent's Name (First, Middle,	Last)					2.	Date of Deat Month	th Day	Year		me of I	Death
	Physicia /Medic		CHENG IL KI	1					A	pril	29	2006	$\frac{1}{2}$:55	РМ
	Examin		4a. Facility Name (If not institution,	_	mber)		4b. City, Town,					County of Dea			
			1 Memory Court	6. Sex	7. Age (In yrs.	lact high days	Silver	Sprin		Date of Birth	1	Montgor		te to or	Corpina
	Funeral Director		5. Social Security Number 214.11.5143	1 M 2 F	62	Yrs.	Months Days		Min.	(Month, Day,	Year)	943 Jap	nthplace (Sountry)	iai o or	roreign
			Usual Residence of Decedent		02				INC	00. 12	,	/45 Oup			
	how		10a. State 10b. County			ty, Town or Lo							10d. Ins		
	Ba-f-	cto	Maryland Montgo	mery	S	ilver	•							Yes	2 🗆 No
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	ter de	'n.	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Armed Fo	orces?	.5.	f Yes, specify Cul	ban, Mexican,	Puerto Rica	an, etc.)		Black, Wh	le, elc.	cai i,	
936	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	V 0		1 ☐ Yes 2 🖾 No	Specify:			İ	Specify: AS	ian		
Š Q	72 ho natur	Completed	15. Decedent' (Specify only highest			16a. Dece	dent's Usual Occu	pation	of working		16b. Kir	nd of Business	/industry		
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Maryland 21215-0036	thould Me Me mark	ဥ	Jae IK K1m 19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Stree					Town. State.	Zip Code)		
Ma	od 2 sellth ar		Myung Ae Kim/Wi				nory Cou							14	
ē,	f Hee		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla	ace)	Date		20c. Lo	cation - City o	r Town, Sta	ate	
Ê	Pege nent o nt: #		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		Mem. Par		5/06/2	2006	01ne	y, Mar	y1and	l	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other treumatic event, the Medical Exacilment and the multilled at 200.		21. Signature of Funeral Service L	icenses	t	22 H	Name and Addr INES-RIN 1800 New	ess of Facility ALDI FU Hampsh	UNERAI nire A	HOME	, IN	C. r Spri	ng, M	ID 2	20904
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a	Physician		Immediate Cause (Final disease or condition		pirator								72 H	and D	
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Division of Vital Records,	ding After funer	tlon: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig	28a. Date (Mor	Inpatient 2 of Injury oth, Day Year)	28b. Time of Injury	28c. Inju	4 14013	28d.	. Describe ho		Other (Special occurred	ecity)		
Divisi	or Attending efter death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place	e of Injury - AI h ling, etc. <i>(Speci</i> i	ome, farm, str fy)	eet, factory, office		28f.	Location (St. City or Town		l Number or F	ural Route	Numb	eer.
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•	0		XQ	De 100	1		NC	00 51	17 10)	May	2, 200	6		
	5		30. Name and A dress of person v							210//					
			Henry Rosas, N					, Mary	rand 2	41044					
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 4	2006	Registrar's Signa	tr.	selv.								

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** May 6, James Aloysius Lacey 2006 5:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12 M 2□F 74 216-40-5068 July 6, 1931 Director Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-f ehow any injury or other traumatic event, if a Medical Examinar many injury or other traumatic event, if a Medical Examinar many ence. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 No Director St. Mary's Maryland Chaptico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23644 Hurry Road 20621 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 X Married 1 Tes 2 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Tobacco Farmer Agriculture 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Walter Benjamin Lacey Mary Ada Quade 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Jean Lacey / Wife 23644 Hurry Road, Chaptico, MD 20621 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery May 12, 2006 Bushwood, Maryland 21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 Tardiner Maex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between nset and Death Hypory em A Immediate Cause (Final HUPOTENSIUN Pnysician disease or condition resulting in death) /Medical s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the ettending physicien and ned for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been signi rector, page 2 should be 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 2. No 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date sygned (Month, Day, Year) 29b. Signature and title 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 Three Notch Road Hollywood, MD 20636 David M. Federle, M.D. 31. Date filed (Month, Day, Year) State 9 2006

Registrar

MAY

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 10:00 **Physician** May 5, 2006 John Phillip Lange /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** St. Mary's 21540 Port View Circle Leonardtown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 23, 1914 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 11 M 2□ F Months 91 Maryland Director 224-60-6017 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "netural", or items 23a or 28a-f show traumatic event, the Madical Exarcition mant be notified at 1 ☐ Yes 2 🕅 No Directo St. Mary's Leonardtown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Port View Circle USA 21540 20650 by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ YYes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Aeronotical Engineer U.S. Government 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 is marked oth eny injury or other traumatic event once. Clara Frick John Adam Lange 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21540 Port View Circle, Leonardtown, Maryland 20650 Phyllis Anne Lange / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Francis Xavier 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 9, 2006 Leonardtown, Maryland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Cardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MONTHS **Physician** bladder Metastate disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) physicien a s the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 140 2 this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation nersi Director: A filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funersi Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifies D 20177 105/2006 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO THREE NOTCHRO MECHANICSVILLE 28227 JAYARAMAN KRISHW A 31. Date filed (Month, Day, Year) MAY 9 2 2. Registrar's Signature State 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 29, **Physician** 2006 a M 1:45 Felicita Lopez-Lau /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 🖾 F 30, 1919 Peru 87 Jan. 141-70-4953 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other then "naturel", or items 23a or 28a-1 show mary injury or other treumatic event, the Modical Examinar must be notified at our 10b. County 10a. State 1 ☐ Yes X ☐ No Director Maryland Prince George's Riverdale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20737 Peru 5003 Ravenswood Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify:White Specify: Peruvian Saltimore, Maryland 21215-0036 ¥☐ Yes 2☐ No þ 3℃ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Juana Portuguez Santos Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5003 Ravenswood Road, Riverdale, MD 20737 Victor M. Lau-Lopez/ Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 4 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, MD 20901 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Physician Debility, Generalized /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequency off Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖳 known History of Sepsis, Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Decubitus Ulcer, Congestive Heart Failure certificate has ormed? 2 ☐ No 1 TYes Pneumonia Hospital or Attending Physician: 4 hours after death. Funerel Director: After this certifica : After this certifica e funeral director, r 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 ⊠Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a to Certifying Physician: To the best of my knowledge, death conursed at the time, data and plana, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Curtilior Medical (Check only

State Registrar

KHETAN. SURESH K, 32 Registrar's Signature 31. Date filed (Month, Day, Year) 04 2006

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

ini

29b. Signature and title of certifier

MD 7610, CARROLLANE HE 260 TAROMAPANIK MD 2091L TO BUSI

29c. License number

D55403

29d. Date signed (Month, Day, Year)

5/2/06

	1 _ State	Department of Health and Mental H Certificate of Death	ygiene 006 15745
	Decedent's Name (First, Middle, Last)	2. Date of ✓Month	Death 3. Time of Death
Physician /Medical	Jesse Douglas Lunsfor	d Apri	1 26, 2006 12,29,4 M
Examiner	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Death Lanham	Prince Georges
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday) If Under 1 Year If Under 24 Hrs. 8. Date of I Months Days Hours Min. (Month,	Birth 9. Birthplace (State or Foreign Country)
Director	242-66-8740	Yrs. June	North Carolina
/land	10a. State 10b. County 10c. City, Tow	m or Location	10d. Inside City Limits
e Man Miled ctor	Maryland Baltimore Ba	ltimore	1 ☐ Yes 2X No
dith the right the road	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Sforth S Inter death with the Mar Article 23 or 28a1 o drar must be notified Funeral Director	2226 Vailthorn Road 11. Marital Status 12. Was Decedent Ever in U.S.	21220 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	United States No- 14. Race - American Indian,
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland free 31 and 2 should be filed within 72 hours after death with the Maryland fleen 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 No Retire	d If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:	Black, White, etc. Specify: Black
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TOUCH SECONDICE TO TOUCH STORY IN THE STORY	Elementary/Secondary (0-12) 2 College (1-4or 5+) 2 years	Military Enlisted	United States Air Forc
ind 2 be filed tal Hygind other event, III	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	_
aryland aryland should be fifte should be fifte should by unatic event To Be (Luther Lunsford 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b.	b. Mailing Address (Street and Number or Rural Route Nur	Dixon nber, City or Town, State, Zip Code)
b, Mar. and 2 shr m 27 is m her traum	(MITE)	406 Suda Drive: Durham, No	
S 1 ar Si Hea	20a. Method of Disposition 20b. Place of cameta	of Disposition (Name of ery, crematory or other place) April 29,2	20c Location - City or Town State
imor Pages ment off ant: if it	1 MBuriai 2 Cremation 3 Hemoval from State	gh Memorial Cemetery	Raleigh, North Carolina
Baltimore, Baltimore, permit. Pages 1a Department of He Important if them eny injury or othe	21 Signatury of Funeral San o Licensee	R. N. Horton Company Mo: 600 Kennedy Street, N. W.	rticians, Inc. Washington,DC. 20011
	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line,		
Physician	Immediate Cause (Final disease or condition resulting in death)	sprating taring	Onset and Death
/Medical Examiner	Due to (or as a consequence	off:	
er er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence	of):	
D, executed in and ial-transit	cause, Enter Undertying Cause (Diseese or injury that initiated events c.	broughtula accide	
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58760, icate be exphysician subburial	d		
P.O. Box 6 nat the death certifi d by the attending, letached for use as	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	h 2 Seterio reggoso	23d. Date of delivery
Geath death	in the past 12 months? The past 12 months? The past 12 months	h 3 Ectopic pregnancy 5 Other (specify)	Month Day Year
Is, P.O. I res that the de isgned by the a be detached to by Physic by Physic	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I 23e. D	id tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box tor Attending Physician: The law requires that the death cer after death. The certificate has been signed by the attending in by the funeral director, page 2 should be detached for use ertification: To Be Completed by Physician/Nertification:		3	☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown
cords w require si been signified.		24a. W	as an 24b. Were autopsy findings available
Il Record The law requir cate has been s page 2 should		at per 1 \subseteq Ye	prior to completion of cause of death? s 2 No 1 Yes 2 No
of Vital Rec Physician: The lav this certificate has al director, page 2	25. Was case referred to medical	26. Place of Death (Check on	ly оле)
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Division of the or Attending President Gebra in Director: Affect ed in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
Di ital or rafturation lied in			
Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death certificate hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledg (Check only cone)	ge, death occurred at the time, date and place, and due to t and/or investigation, in my opinion, death occurred at the time.	ne cause(s) and manner as stated. ne, date and place, and due to the cause(s)
To the I within 2 To the Complete	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	> Aux HX/M	MDD31357	4-27-2006
(R(10)	30. Name and address of person who cor plite use of death (I in 29a)	MDD31357 NgtoN 8118 Good L	2070
	31. Date filed (Month, Day, Year) 32. Resistrate Signature	Ngton 8118 Good	-UCK KD. LANDAM MD
State Registrar	MAY 0 4 2006		

			For Stata Registrar	State of Ma	aryland / De <i>C</i>	oartmen e <i>rtificat</i>			and Me	-	giene Reg. No.	2006	15	746
Ī	Physicia /Medic		Decedent's Name (First, Middle, L CONSTANCE MU	VADGAH MOB	IT LAR					2. Date of De Month APRIL	24.	2006	1704	f Death M
	Examin Funeral	er	4a. Facility Name (If not institution, grant Montgomery General States Social Security Number 6.	al Hospita	1 e (In yrs. last birthda	01	ney	If Under a		8. Date of Bir	Me	County of De		or Foreign
	Director		217-37-0200 Usual Residence of Decedent 10a. State 10b. County	1⊠M 2□F	46 Yrs.		Days	riours		(Month, Da Oct. 2	1.19	59 C	ameroon	, W.A.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Evantinal must be nuitified at ODGs.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1 MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What County 1308 Morningside Drive 20904 Cameroon, W 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Armence Black, White, 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Education (Specify only highest grade completed) (Give Kind of Work done during most of working life. Do NOT use retired) 15. Decedent's Education (Give Kind of Work done during most of working life. Do NOT use retired) 16b. Kind of Business/Inc (Give Kind of Work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)									W.A. nerican Indian, nite, etc. lack s/Industry Zip Code) 20904 or Town, State W.A.	ity Limits 2 □ No	
8760,	death certificate be executed Medical Examine A for use as the burial-transit	dical Examiner	23a. Pawf. Enter the disease, or conspock, or heart failure. List only mediate Cause (Final dish se or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury that initiated events resulting in death) Last	a Due to (or as b Due to (or as c	ne.	BRENKS		g, such as	cardiac or	respiratory a	rrest,		Approxima Interval Be Onset and	ween
P.O. Box 6	es that the gned by th be detache	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	4 Pregnant at 9 Unknown contributing to death b	2 Fetal death :	B Ectopic profit of Control of Co	ecify)	en in Part I.		23e. Did t	obacco us	/	_	
tal Recol	itcian: The law requir certificate has been si rector, page 2 should I	e Completed	25. Was case referred to medical					26 Place	of Death	24a. Was autor perio	osy rmed? 2 No	24b. Were a prior to death?	autopsy findings completion of c	available ause of
Division of Vital Records,	ittending Physideath. ctor: After this y the funeral di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 3 Suicide 6 Could not determine	be 28e. Place of Inj	28b. Time Injung	of 2	8c. Injury Work 1 🗆 Y	ar: 4 □ Nui	rsing Homo 28	e 5 Resident	dence 6 how injury	d Number or F	ecify) Rural Route Nurr	iber,
ō	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical Cert	29a. Certifier 1☐ Certifying F	building, et thysicien: To the best ominer: On the basis o and manner st	of my knowledge, de f examination and/or	ath occurred investigation,	at the tim	ne, date and pinion, deat	d place, an	City or Tow nd due to the d at the time,	cause(s)	and manner a	as stated. le to the cause(s	·)
^	To the within 2, To the I complet	Me	29b. Signature and title of certifier	PO (DAME)		290	. License	number			4	e signed (Mor	nth, Day, Year)	
1	6		30. Name and address of person who	(1) Mo 11	ru Rockvil	e, Print)	ROCH	whie	s on	0852				
	Sta Registr	-	31. Date filed (Month, Day, Year) MAY 0 4 200		ar's Signature	all!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMend #23E FH G857 7/10/0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** RENEE 2006 1:30A JEAN MUNDAY MAY/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PLATA

Tear | If Under 24 Hrs. CHARLES lll ORÏOLE LANE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 🖾 F Yrs Director DEC.14,1948 IOWA 567-78-8878 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at ty⊒Yes 2 No Directo LA PLATA MARYLAND CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ŏ 20646 Items 23a 111 ORIOLE LANE U.S.A. Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes ADNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: WHITE 3 Widowed WDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT CSM 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BETTY SOLBRIG MAURICE MUNDAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5787 SOLHEIM CUP DR., HAYMARKET, VA20169 CHRISTINE J. MILLER-DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of F Important: If ite any injury or ot once. 1 Burial XXCremation 3 Removal from State
4 Donation 5 Other (Specify) METROPOLITIAN CREMATORY 5-17-06 ALEXANDRIA, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M00479 RAYMOND FUNERAL SERVICE, P.A. I.A. PLATA, MARYLAND 20646 The mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of caused the death. Immediate Cause (Final disease or condition resulting in death) Priysician 02 PHAC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Ö 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes P.O. 9 Unknown 9 Unknow ģ 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 4XXInknown 1 ☐ Yes 2 ☐ No bably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5☐ Pésidence 6 ☐ Other (Specify) 2 1 🗌 Yes this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 27 Manner of Deat Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Momicide within 24 hours a Dectifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifier

31. Date filed (MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

2006

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32. Registrar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink										
tephen James				ntal Hygiene						
		For State Certificate of Registrar	Death	Reg.	No.	3. Time of Death				
Physicia Medical Exami		Decedent's Name (First, Middle,Last) STEPHEN JAMES MONTAGUE			Day Year	1947 hrs				
_			4b City, Town, or Location of Death		4c. County of Death					
A .		9303 Southmoor Court	Upper Marlboro		Prince George's					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min.	_	(MM/DD/YYYY) 9 Birt Foreig	n				
Director	L	$219-72-5068$ $ 1 \times M 2 = F $ 49 Yrs.		APRIL	19,1957 ^{coi}	intry) DE				
'n	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	ion			10d Inside City Limits				
nd show s	١	MARYLAND PRINCE GEORGE'S UPPER	MARLBORO			1 Yes 2 X XNo				
daryland 28a-f show any dat once.	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	try?				
with the Maryland ns 23a or 28a-f sho be notified at once		9303 SOUTHMOOR CT.	20772		U.S.A.					
th with	Funeral		s Decedent of Hispanic Origin? (Sp es, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,				
er dea		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:		Specify: WH	ITE				
urs aft tural"	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	nt's Usual Decupation (Give kind of v		6b. Kind of Business/I					
72 hor "na al Ex	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use reti	red)						
5-0036 led within 72 hours after Hygiene. other than "natural", o	Completed		NISTRATOR	/First Middle Ma	IBM					
ひ 2 英 2 年	Be Co	17. Father's Name (First, Middle, Last) JAMES EUGENE MONTAGUE		e (First, Middle, Ma TE RUTH	PADGETT					
212 uld be Menta mark			g Address (Street and Number or I			Zip Code)				
1D 2 sho 27 is mati		JAMES E. MONTAGUE-FATHER 7421	ROBIN RD.,LA	PLATA,	MARYLAN	20646				
ore, M ss 1 and 2 of Health If item 2		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or other contents.	sition (Name of cemetery, her place)	Date	20c. Location - City or	Town, State				
Pages nent of ant: If or othe		4 Donation 5 Other Specify: RESURRECTION C	EMETERY 5-	13-06	CLINTON,	MARYLAND				
Baltimore, permit. Pages I ar Department of Her Important: If ite	-	21. Signature of Funeral Service Licensee M00479 22. N	Name and Address of Facility AYMOND FUNERA	L SERVI	CE, P.A.					
	-	23a. Part I. Enter the disease, or complipations that caused the death. Do not enter the				Approximate Interval				
Physician /Medical		failure. List only one cause on each line.		, ,		Between Onset and Death				
Examiner		Immediate Cause (Final disease or condition resulting in death) Intraoral Snotgun vvound Due to (or as a consequence of):								
		Sequentially list conditions, b.								
	Examiner	if any, leading to immediate cause From Underlying Gause (Disease or injury that initiated								
od o	xar	events resulting in death) Last Due to (or as a consequence of):								
0, c be executed sician and ourial - transit	g	d. UNPENDED AMENDED								
× 68760, h certificate be exe tending physician a use as the burial -	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery					
587 ertifica fing pl	an/l	23b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregna	ancy	Month E	ay Year				
OX 6 eath cer attendi	sici	1 Yes 2 No 9 Unknown 9 Unknown	ther (Specify)		1					
Records, P.O. Box 68760, he I.w requires that the death certificate be executed it are has been signed by the attending physician and age is should be detached for use as the burial - transi		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?				
, P.(res tha signed be det	d by			1 Yes	2 No 3 Prob	ably 4 Unknown				
cords, w requir as been s	Completed			24a. Was ar autopsy		topsy findings available ompletion of cause of				
eco helw atekas age	omp			perform 1 V Yes 2		s 2 No				
tal F cian: certifi ector,	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)						
Vit Physic r this c	ToE	1 Yes 2 No Inpatient 2 ER/Outpatient			esidence 6 🗸 Other	Scene				
Division of Vital Records, P.O. rat or Attending Physician: he I w requires that the rs after death all birector: After this certificate has been signed by led in by the funeral director, age, should be detact		27. Manner of Death 28a. Date of Injury 28b. Time of Country 1 Natural 5 Pending FOUND: 280. Time of FOUND	Injury 28c. Injury at Work? 1 Yes 2 ✓ No	Deceased sh	w injury occurred ot self					
isio Atten r deat ector by the	icati	2 Accident Investigation May 6, 2006 1940 hrs		28f, Location (St	reet and Number or Ru	ral Route Number, City				
Div tal or rs afte	Certification:	3 V Suicide 6 Could not be determined (Specify) Single Family		or Town, Sta 9303 Southm	^{ite)} ioor Court, Upper	Marlboro, MD				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu								
To the within 2 Vo the Complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.								
F 3 F 3	ž	29b Signature and little of certifier	29c. License number	1	29d. Date signed (Mo.	nth, Day, Year)				
^		AICUN /VI	O.C.M.E.		May 7, 2006					
10		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Pel	nn Street, Baltimore, MD 2	1201						

Registrar

State 31 Date filed (Month, Pay Year) MAY 1 8 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1200 PM Ellsworth McCarty 2006 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 10, 1945 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 10X M 2□ F Yrs 215-44-9367 60 Maryland Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County il Hygiene, other than "natural", or Items 23a or 28a-1 ehow vent, the Medical Examinar must be notified at 1 X Yes 2 ☐ No by Funeral Director Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21740 U.S.A. 828 Georgia Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 \ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Moving and Storage 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny liqury or other traumatic event OREs. 17. Father's Name (First, Middle, Last) Svlvia I. Berneker Andrew Leroy McCarty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 828 Georgia Ave., Hagerstown, MD 21740 Claudia Suffecool/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/16/2006 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee S. Man 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Oronary **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physicien and 1 be detached for use as the burial-transit or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Stomach CRY 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 To the Hospital or Attending Phys within 24 hours efter death.
To the Funeral Director: After this completely filled in by the funeral dir this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NO60396 05/12/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 MURSHED ARID 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death $\texttt{May}^{\texttt{Month}}$ Day **Physician** Teresa 14, 2006 (Allgauer) Mason 12:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3 Richard Way LaVale Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 19 1909 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 96 West 232-56-7093 Virgini Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural; or Items 23a or 28a-f show 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits Examiner coust be notified at MD Allegany LaVale 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 3 Richard Way USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☑ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna (Schmidle) Allgauer Herman Allgauer 19a. Informant's Name/Relationship (Type, Print) Daughter* 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Richard Way, LaVale, MD Hester Alice Neely 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 17 06 Reedsville, WV Morgan Mem Park ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Enysician ARTERIOSCLEROTIC H242T DESEASE ONE TEXA disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and The law requires that the death certificate be executed Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Dale of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ٩ 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) within 24 hours a To the Funeral I 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-14865 /Coustions Janer. 30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

Registrar

State

ROBUSTIAND

31. Date filed (Month, Day, Year)

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32. Registrar's Signatur

BARRERA

MEMORIAL MEDICAL BLDG. CUMBERLAND MD 21502

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician May 1, 2006 7:20 P_M Nadline Viola Morsha-Taylor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital
Social Security Number | 6. Sex | 7. Age (In yrs Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 □ F Yrs. Feb 28, 1981 Maryland Director 216-04-6197 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits worde rei', or items 23a or 28a-f ehov Examiner must be notified at 1 Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 20903 USA 9722 Hedin Dr Funeral t2. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be tiled within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel; or item eny injung or other traumatic event, the Madical Examina 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madline P. Frazer Herbert V. Morsha-Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9722 Hedin Dr. Silver Spring, MD 20903 injury or other to Herbert V. Morsha-Taylor/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem May 13, 2006 Adelphi, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service License any ir 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sickle **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 months Hebatic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 4∏Pregnant at time of death 5 Other (specify) signed by the a detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificale 1 Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending Injury r death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3348 May 2, 2006 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANAND SAJEEU 7600 Carroll Ave, Takoma Park, MD 20912 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 04 2006 Registrar

		•	For State Registrar	State of Maryland	-	artment of H			iene g. No.	06	15752
	Physicia	an	1. Decedent's Name (First, Middle, Last) Rose Myers	Magruder				2. Date of Deat Month May 4	Day	Year	Time of Death 4:25 A M
	/Medic Examin	al	4a. Facility Name (If not institution, give st			4b. City, Town, or	r Location of E		4c. County of		4.23 A
	Examin	ei	Southern Maryland		cute	Clinto			Prince	Georg	e's
	Funeral Director		5. Social Security Number 211-12-9191 6. Sex Usual Residence of Decedent	7. Age (In yrs. It	ast birthday) Yrs.	ff Under 1 Year Months Days		Hrs. 8. Date of Birth (Month, Day, Jan. 3,	1924 P	9. Birthplace Country ennsy	(State or Foreign Vania
	/land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. i	Inside City Limits
	e Man	ctor	Maryland Charles		Wal	dorf					1 □ Yes 2√□ No
	with th	Dire	10e. Street and Number			10f. Zip Code	20602	1	0g. Citizen of W	hat Country?	
	Jeath 1	erai	11760 Quade Court	2. Was Decedent Ever in U.S	S. 13. \			? (Specify Yes or No- uerto Rican, etc.)	14. Race	- American Ir	ndian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23a or 28s-f show any injury or other traumette event, the Medical Examinat mout be notified at angle.	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🗙 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 🛛 No	Specify:	Puerto Rican, etc.)	Specify:	k, White, etc. Whit	te
5	72 ho	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of	f working	16b. Kind of Bus	siness/Industr	У
7	withir iene. then	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Bank Tell	•		Banki	ing	
g	al Hyg	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle, I		э)	
ylaı	ould b Ments varked	To	John Elmer Myers					argaret Bo		7 7. 0	
Maryland	d 2 sh th and th and ?7 ie m traum		John H. Magruder, J	•				or Rural Route Number Sunderlan			10)
ē,	is 1 and 2. If Heelth are litem 27 is		20a. Method of Disposition	20b. P		sition (Name of natory or other place			20c. Location - (State
<u>E</u>	Page nent o ant: If ury or		1	Res	urrec	tión Ceme	tery5-	8-06	Clinton,	, MD	
Baltimore,	permit. Departitingorts any inj		21. Signature of Euneral Service License	aun Mood	2000	. Name and Addre	-		ld Wash [.] 6, Waldo		
	Physicial and ph	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one shock, or heart failure. List only one shock, or heart failure. List only one shock of the sh	Due to (or as a consequ	pence of):		UCER		951,	Inte	proximate erval Between iset and Death
P.O. Box 68760,	death certifi e attending id tor use as	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	kc. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3[Ectopic pregnancy	,		23d. Date Mon	e of delivery th Day	y Year
	es tha	Ď	Part II. Other significant conditions conf	tributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	es 2 □ No	ibute to the ca 3 □ Probably	
al Records,	The ete h page	Completed							ned? de	Vere autopsy trior to comple eath?	findings available ation of cause of
Vital	Physician: this certificral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatier	nt 3 DOA Oth		Death (Check only on ng Home 5 \subseteq Reside		r (Specify)	
n of	ding Phys h. After this funeral di	on: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho			
Division	or Attention of Attention of Attended the Charleston: in by the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify			Yes 2 □No	28f. Location (St City or Town	reet and Numbe n, State)	er or Rural Ro	ute Number,
_	Hospital 4 hours e Funarel I	edicai Co	(Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examinat	wledge, deat tion and/or in	h occurred at the tir vestigation, in my o	ne, date and p	l place, and due to the co occurred at the time, d	ause(s) and mar ate and place, a	nner as stated	t. cause(s)
	To the I	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed	(Month, Dey,	Year)
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1	01 95		Pr W (SOYSICY A)	mpleted cause of death (Item (1,0) 1,2070	O(1)	LINE CE	KRR	WACARLA	Flad	. 20	602
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Physician December Name / First Medical as S. Miller S. December			For State Registrar	State of Maryland	d / Depar	rtmen		-		2006	1575
Clara S. Miller Extended	S DOWN			ist)						y Year	3. Time of Death
## A. Facility Name (Incident seasoned proximate and number) ## Montgomery Ceneral Hospatial Hospat			Clara S.	Miller							11:47A
Social Security Number Social Security Numbe			4a. Facility Name (If not institution, gi	re street and number)		4b. City,	Town, or Location of D	eath	4c.	County of Death	
231-36-1207 Continued Co		2,5			- A b :- 46 - 4- 3			dre la B-1 (D)	M	ontgomer	у
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of contribute to	ysici		•	d							
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24a. Was an autopsy findings performed? TYPES 2 No. 3 Probably 4 1 24a. Was an autopsy performed? TYPES 2 No. 1 Probably 4 1 24b. Were autopsy findings prior to completion of compl	d by setacl		-	contabuting to death but not recul	Iting is the und	doshina o	auco grupo in Part I	23a Did	obaccou	ise contribute to	he cause of death?
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Mithin To th	Me	29b. Signature and title of certifier	.000		290	License number		29d. Dat	e signed (Month,	Day, Year)
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	(5)		30. Name and address of person who	completed cause of death (Item							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curtis Ollayds, M.D. 18101 Prince Phillip Dr. Olney, MD)		Curtis Ollayds,	4.D. 18101 Pri	ince Ph	nilli	p Dr. Oln	ey, MD			
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			For State Registrar	State of N	Naryland / De		tment of Heificate of L			Re	eg. No. <u></u>	006	15	754
e de la companya de l	Physici		Decedent's Name (First, Middle, Last Mary Carolyn	N eid ho	1d					Date of Deat Month Dril	Day	Year 2006	3. Time of 11:10	
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-	Funeral Director		141-28-3446	7. /] M 2 F	Age (In yrs. last birthdi 71 Yrs	7/	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, -28-19	Year) 35	9. Birth Cou New	olace (State ontry) York	or Foreign
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036	be filed within 72 hours after death with the Maryland stal Hygiene. Ind other then "natural", or Itams 23s or 28s-f ehow event, Ira Micilical Examinar mark to rediffice as	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Date:	No		as Decedent of His Yes, specify Cubar		gin? (Speci , Puerto Ric	fy Yes or No- can, etc.)	14.	Race - Amen Black, White, pecify:	can Indian,	
21215-0036	Men.	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		(G	ive ki e. Do	nt's Usual Occupa ind of work done d O NOT use retired, ner	urina most	of working			of Business/Ir	ndustry	
Maryland 2	12 should be filed v and Mental Hygie 1e marked other t raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) William Lanigan						rs Name (i	First, Middle, I				
aryl	2 should and Meni le marke sumatic	F	19a. Informant's Name/Refationship (7	ype, Print)	19b. M	ailing	Address (Street a	nd Numbe	r or Rural F	Route Number	; City or T	Town, State, Zi	o Code)	
	and ealth m 27		Kim N. Michie/Dau 20a. Method of Disposition 1 Burial 2 Cremation 3 D		20b. Place of Di	D sposi	rexel Dr tion (Name of atory or other place	ive.	Mille Dat	rsvill	20c. Loca	21108 ation - City or T	own, State	
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or otl		4 Donation 5 Other (Specify 21. Signature Funeral Service Light Edward N. Brins	see 2	Trinity	22.	iscopal Name and Addres 955 Holl	s of Facility	y Brin	sfield	Fune		me, P.	Α.
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or compshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, is aurige to mimediate cause. Enter Underlying Cause (Disease or injury	aDue to (or	as a consequence of)	Te s		g, such as	cardiac or r	espiratory arm	est,		Approxima finterval Be Onset and	tween
). Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 Yes 2 No	d23c. If yes, outcome 1 □ Live birth	2 Fetal death tat time of death	3 □E	Ectopic pregnancy Other (specify)				23	d. Date of delin	•	Year
ds, P.0	ires that the signed by th d be detach	d by Phy	9 Unknown Part II. Other significant conditions of the significan	ontributing to deat		ne und	derlying cause give	en in Part I.			bacco use	e contribute to		death? Unknown
Vital Records,	The ate h page	Completed by	Type 2 c		es me	د	itus			24a. Was a autops perfore	an sy med? 2 No	24b. Were aut prior to c death? 1 \subseteq Yes	opsy findings ompletion of	available cause of
Vita	Physician: The this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			3FL DOA Othe	200		Check only or				
o	fter ner	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		ne of	28c. Injun	4 🗀 140	28	e 5 Heside		Other (Spec	ify)	
Division	or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	9 28e. Pface of	Injury - At home, farm, etc. (Specify)	n, stre				If. Location (S. City or Town		Number or Ru	ral Route Nur	mber,
0	Mospital 24 hours Funeral letely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the be niner: On the basi and manner	est of my knowledge, os of examination and/or stated.	death or inve	occurred at the tin estigation, in my o	ne, date an pinion, dea	d place, ar	nd due to the c if at the time, d	ause(s) a late and p	ind manner as place, and due	stated. to the cause(s)
h'	To the within 2 To the complete	Me	29b. Signature and title of certifier	AA	when Mo	P,	29c. Licensi 94	636	0		$\mathcal{M}_{\mathbf{A}}$	signed (Month	, Day, Year) 200	6
			30. Name are address of person who MICHAEL ANK POL		of death (Item 23a) (Ty	ype, F	Print)	Mill	eesi	nue	MI	21	108	
3	St Regis	ate trar	31. Date filed (Month, Day, Year) MAY 9 200	2. Reg	istrar's Signature	946	E)							

			1 - State Registrar	State of Ma	ırylan				lealth a Death	and Me		jiene leg. No 2 (006	15	755
3	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Mildred		Neim	nan					2. Date of Dea		Yeer	3. Time of 9 : 1 !	Death 5 a _M
	Examin		4a. Facility Name (If not institution, give sommerford Place		ted	Livir		Town, or	Location on the location of th	of Death			nty of Death		
	Funeral Director		5. Social Security Number 6. Security Number 1 - 211 - 26 - 5097	7, Age	72	ast birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 6/26/	1933	9. Birth Con Pen	nplace (State cuntry) nsylv	ar Foreign
(sa)	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside C	ity Limits
	Maryit	tor	MD Howard		C	olumb	ia							1 🖺 Yes	2 No
	or 28c	Director	10e. Street and Number 8220 Snowden Ri	vor Park	. W. S. W.		10f. Zi	Code 21	045			10g. Citizen		untry?	
	eath w	Funeral		12. Was Decedent 8		S. 13. V	Vas Dece			gin? (Spec	cify Yes or No- Rican, etc.)	USA 14. F	Race - Amer	ican Indian,	
36	be filed within 72 hours after death with the Maryland tal Hygiene. Tal Hygiene. Tal Hygiene. Tal Gother then "natural", or iteme 23a or 28a-f ehow other then "natural", or iteme 23a or 28a-f ehow event, I'm Modical Examiner must be notilized at	by Fun	1 Never Married 2 Married 3 ⊋Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			fYes, spe I□Yes		Specify:	i, Puèrto F	Rican, etc.)		Black, White c <i>ify:</i> V	o, etc. Vhite	
9500-61212	72 hou natura ilcal E	sted	15. Decedent's Edu (Specify only highest grade	cation e completed)		16a. Deced	lent's Usu	ial Occup	ation during mosi	t of workin	a	16b. Kind o	f Business/I	ndustry	
	within 72 ene. then "na'	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)				during mosi oerat			Bell	A + 1	antic	
	filed Hygie other	Be Co	1 2 17. Father's Name (First, Middle, Last)			1010	, p.1.0		18. Mothe	r's Name	(First, Middle,			411010	
ylan	교육호교	ToB	William Seiler								Quick				
Maryland			19a. Informant's Name/Relationship (Ty James Neiman/So				-				Route Numbe				
Je,	of Heal	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F	Ismauel from Clata	C	Lace of Dispo emetery, cren	natory or	other plac	ce)		ate	20c. Locatio	-		
Baltimore,	tment of tant: If It		4 □ Donation 5 □ Other (Specify)	//	Ch	rist								s,Pa.	
Ва	permit, Pages 1 and 2 Department of Health 6 Important: If Item 27 I eny injury or other tre		21. Signature 1 Funeral Service Lichis West & Lilli	uldr'							FUNER		RVIC prin	E,P.A g,Md2	910
H			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lin	the death ie.	n. Do not ent	er the mo	de of dyin	ig, such as	cardiac or	respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
j., .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alzh	_	ers D	isea	se_						year	S
ı	Examiner		Sequentially list conditions	0		301100 017.									
	pe psit	nlner	Sequentially list conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or as	3.00/156()	uerine offy									
<u>,</u>	execut in and ial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):									
8760	cate be executed physicien and the burial-transit	dical		d											300
Õ	leath certific attending p	W	IF FEMALE:	3c. If yes, outcome	of pregna	incy						23d.	Date of deli	verv	
O. Box	0 0 0	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	Ideath 3□	Ectopic p Other (s	pecify) _					Month		/ear
<u>.</u>	g g g	y Ph	Part II. Other significant conditions con	ntributing to death bu	ut not resi	ulting in the u	nderlying	cause giv	en in Part I.		23e. Did to	bacco use c	ontribute to	the cause of c	leath?
Sign	w requires to been signed should be	ted t	Depression								1 🗆 Y	es 2 No	3 □ Pro	bably 4X	Jnknown
Vital Records,	: The law r cate has be . page 2 sh	mpie	Seizure disorde	er						_	24a. Was autop	n 24 sy med?	b. Were aut prior to c death?	topsy findings ompletion of c	available ause of
酉			25. Was case referred to medical						26 Place	of Death		2√2 No		2 No	
<u> </u>	Physician: this certific al director,	To Be	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 🗌 Inpatie	nt 2 🗆	ER/Outpatien	it 3 🗆 D	OA Oth			ne 5□ Resid		Other (Spec		
o uc	ding Ph h. After th funeral		27. Manner of Death 1	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	M	28c. Injur Wor	yat k? Yes 2 □		8d. Describe h	ow injury oc	curred	11711	ıg
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At ho c. (Specify	ome, farm, str					8f. Location (S City or Ton		mber or Ru	ral Route Num	ber,
	To the Hospital within 24 hours and the Funeral completely filled	Medical Co	29a. Certifier 157 Certifying Phy (Check only one) 157 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examina	wledge, death tion and/or in	n occurre vestigatio	d at the tir n, in my o	ne, date an pinion, dea	d place, a th occurre	nd due to the o	ause(s) and late and plac	manner as ce, and due	stated. to the cause(s	i)
	To the within: To the somple	Me	29b. alignature and title of course	5			25	c. Licens	e number			29d. Date sig	ned (Month	, Day, Year)	
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	10		30. Name and address of person who co			23а) (Турв,		to	25 Dr	C	SUMB	ici N	1	0 1000	
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture			اره ۱			(c) t		XIOY	7
	Regist	rar	MAY 04	2008	var.	15 /	1								

		-	- For State Registrar Amend Iter		aryland / Dep	artment of H	lealth and N	lental Hyg	_	06 15756
	Physicia		1. Decedent's Name (First, Middle,	Last)	^	_ /		2. Date of Dea Month	th Day	3. Time of Death
	/Medic	al -	Charlott	2 17.	OUTT.		Location of Death	04	4c. County	of Death
4	Examin	er	4a. Facility Name (If not institution, LAURELWCOD	give street and number) CARE (E~)		46. City, Town, or		20		FCIL
	Funeral Director				e (In yrs. last birthday)			8. Date of Birth (Month, Day	Year)	9. Birthplace (State or Foreign Country) Delouse
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	hours after death with the Maryland turel; or Items 23a or 28e-1 show at Examiner must be rediffed at	ō	MD Cecil		E1kton					1 ☐ Yes 2 No
	28e-	rect	10e. Street and Number	·	Bittebi	10f. Zip Code			log. Citizen of V	Vhat Country?
	h with	ai D	100 Laurel Roa	d	ξ.	2192	1		USA	
	ems a	iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - American Indian, k, White, etc.
36	s afte	y F.	1 ☐ Never Married 2 ☐ Marrie 3 ☑Widowed 4 ☐ Divorced	If Yes, Give	No		Specify:		Specify	white
90	turel'	Completed by Funeral Director	15. Decedent's	Year or Dates:	16a. Dece	edent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry
15	n ne	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of work d)	ring		,
212	e filed within al Hygiene. i other than ' vent, it e we	Com	12		cle	rk				id Drugs
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, L	•			18. Mother's Nam		Maiden Suman	ne)
Σ	2 should be and Mental Is marked o aumatic eve	은	Samuel Edwin T		10h Mail	ing Address (Street	Mary E	·····	r City or Tour	State Zin Code)
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan Fhailth and Mantal Hyglene. Fhealth and Mantal Hyglene from 27 Is marked other than "neturel", or items 23a or 28e-f show item 27 Is marked other than "neturel", or items 23a or 28e-f show other traumatic event. It a Modical Examinar must be rediffied at		19a. Informant's Name/Relationsh			Hull Ave			19711	State, Zip Code)
	t Health Health Hem 27 I		Terry E. Outte 20a. Method of Disposition	n (son)	20b. Place of Disp			Date DE		City or Town, State
ê E	. Pages 1 ar tment of Heal tent: If item ? ijury or other		1 Ma Burial 2 ☐ Cremation 4 ☐ Donation 5 🔝 Other (Sp			awn Mem.		2,2006	New Ca	stle, DE
Baltimore,	E a o E ai		21. Signature of Funds I service I	icense /	788 2	22. Name and Addres	ss of Facility	Crery F	uneral	Homes, Inc.
<u>m</u>	Ded Imp	4.3	1/ jupolos de	Moule		3924 Conc	ord Pike	Wilmin	gton, D	E 19803
	Physician /Medical	e.	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	Nee 70	7 LLH W	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Examiner				a consequence of):	Talun=				
	usi s	Jer.	Sequentially list conditions, tray leading to immediate cause. Enter Underlying		a consequence of:	1 1911000				
	sician and burial-transit	Examiner	that initiated events	c. Eu	STAGE	Demons	2			
760,	te be executed ysician and e buriat-transit		resulting in death) Last	Due to (or as	a consequence of):					
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.O. Box 6	The law requires that the death certificat tte has been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	,		1.7	te of delivery nth Day Year
Δ.	that the ed by detac	/ Ph	Part II. Other significant condition	ns contributing to death b	out not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use cont	ribute to the cause of death?
Vital Records,	quires n sign .ld be	d by				<u>-</u>		1 🗆 Y	es 2 🖬 No	3 Probably 4 Unknown
Ö	law require as been sig 2 should b	Completed						24a. Was a	an 24b.	Were autopsy findings available prior to completion of cause of
Re	The la	E O						perfor	med?	death?
ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or	ne)	
	Physicien: this certificated ral director, i	2	1 ☐ Yes 2 ☐ No	Hospital:			4 Avursing m	ome 5 Resid		
nc	After Arten	tion	27. Manner of Death 1-Natural 5 Pending 2 Accident investig	28a. Dat y of Inju (Munth, Da	ury 28b. Time (lnjury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occur	60
Division of	Attending or death. ector: After by the fune	fica	3 Suicide 6 Could n	ot be 28e. Face of I	jury - At home, farm, s			28f. Location (S	treet and Numb	er or Rural Route Number,
Ο̈́	after after t Dire	Certification;	4 Homicide	fuilding,	tc."(Specify)			City or Tow	n, State)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C		Physician: To the best examples: Or the basis of and magner st	of examination and/or in					
	To the within 2 To the complete	Ž	29b. Signature and title of certifier			29c. Licens			_	d (Month, Day, Year)
			•	1111			073		DI MA	706
	Ц		30. Name and address of person of Store	vito completed cause of	death (Item 23a) (Type	n, Print)	CTO	NEWLA	1571E	DE 19720
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	817 Cr rar Signature	1 Small	'	11-100	. 🗸	110 1.100
	Regist	rar	πA	I A 9 KAAR	MARINE A	- //-				

			For State Registrer	State of Maryland	d / Depa <i>Cer</i>	irtment of F	lealth a <i>Death</i>	ınd Mental I	Hygier Reg. t	11/10	16	15	757
	Sec. Vi-		Decedent's Name (First, Middle, Last)					2. Date of	Death		· · · · ·	3. Time o	f Death
	Physicia		Cathe	rine Frances	01ive			Month May		^{Day} 2006	Year	6:00	Рм
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of			4c. County of	of Death		
			36326 Wainwright Ro	oad		Mechani	icsvil	le.		St. Ma	ary'	S	
\$	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 2 Hours	Min. (Month	Birth Day, Yea	ar)		lace (State	or Foreign
	Director		210 70 0097	M 2 🟋 F	37 Yrs.			April	22, 1	919 N	lorth	Caroli	na
	pu *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation					1	0d. Inside (City Limits
	anylan •how	ō											2√∑ No
	28a-	Director	Maryland St. Mary 10e. Street and Number	S IV.	lechan:	icsville			10g. (Citizen of W	hat Cour		Λ
	with the or	ā		ad		206	550			USA		,	
	death with the Maryland ma 23a or 28a-f ehow r must be notified at	Funeral	36326 Wainwright Ro	2. Was Decedent Ever in U.S	i. 13. V	Vas Decedent of H	lispanic Orig	gin? (Specify Yes or	No-		- Americ	an Indian,	
0	riter	필	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1			, Puerto Rican, etc.)		, White,		
3	ef, o	þ	3 ₩idowed 4 Divorced	If Yes, Give A Year or Dates:	1	Yes 2 No	Specify:			Specify:	Whit	e	
9500-6121	within 72 hours after ene. then "naturel", or ite	Completed	15. Decedent's Education (Specify only highest grade	ation (completed)	16a. Deced	ent's Usual Occup	ation	of working	16b,	Kind of Bus	siness/In	dustry	
7	thin 9	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	1)	o. Homing					
N	filed w Hygien other th	S	12		Hom	emaker				Own He			
and	9 7 9 9	Be	17. Father's Name (First, Middle, Last)					r's Name (First, Mic			9)		
	2 should be and Mental ie marked o	2	Clyde F. Jone					Luna Graha					
Mary	es 1 and 2 should b of Health and Ment fitem 27 le marked r other traumatic		19a. Informant's Name/Relationship (Typ					r or Rural Route Nu					
	1 and 1ealth		Thomas Lee Oliver / Son 20a, Method of Disposition			Nainwright sition (Name of	Road, I	Mechanicsvi. Date		Location - (
٥	Peges nent of h int: if its iry or of		1 X Burial 2 ☐ Cremation 3 ☐ Re	CO	metery, crem St Epis	natory of other plac	1				N355		
Baitimore,	rtant rtant		4 ☐ Donation 5 ☐ Other (Specify) 21. Signat0re of Funeral Service License		C	enetery . Name and Addre		ay 11, 2006	Cha	atico.	Mary	land	
n n	permit. Pege Department of Important: ff any injury or once.		Michael	Tardener	Ma	ttinglev-Ga	ardiner	Funeral Ho	me, P.	A.			
			23a. Part I. Enter the disease, or complic	ations that caused the death.	Do not ente			rdtown, Mar cardiac or respirato		_20650_		Approxima	
	niitataa		shock, or heart failure. List only one Immediate Cause (Final									Interval Be Onset and	
	Physician /Medical		disease or condition resulting in death) a.	Due to (or as a consequ	SCUL	AR AC	CIDKI	NT				G H	RS
	Examiner			000 10 (01 23 2 00113040	01100 017.								
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	cuted 3d ransit	Examiner	that initiated events c.										
Ç	an er arial-t		resulting in death) Last	Due to (or as a consequ	ence of):								
8/60	The law requires that the death certificate be executed ate has been signed by the attending physician end cage 2 should be detached for use as the burial transit	dicai	d.								-		
9	ing pl	Med	IF FEMALE:										
ROX	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 	death 3	Ectopic pregnancy	,			23d. Date Mon		ery Day	Year
	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5∟	Other (specify)			-			,	
2	res that the de signed by the a be detached t	Ph	Part II. Other significant conditions cont	ributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e. C	id tobacc	o use contril	bute to th	ne cause of	death?
ds,	uires l signe	d by	DIA GETES			,						ably 4	
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a			05 W					1 🗆 Ye	s 2 X		Yes	2 No	
₹	certif	o Be	25. Was case referred to medical examiner?	ospital:	70.0	Oth	er	of Death Check or			1.00	==	
ö	Physical di	⊢	27. Manner of Leath		R/Outpatien 28b. Time of	I SLI DOA	4 🗀 Nur	rsing Home 5		6 Other		Y)	
on	ding th. Afte	ţ	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury		k? Yes 2∐N	1					
Division of Vital Records,	Atter dea	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, str	eet, factory, office				and Numbe	r or Rura	l Route Nur	nber,
	s afte	Certification:	4 Homicide	building, etc. (Specify,	,			City of	Town, Sta	ate)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	cian: To the best of my know	vledge, death	occurred at the tir	ne, date and	place, and due to	the cause	(s) and man	ner as s	ated.	,
	he He in 24 he Fu	Medical	one)	er: On the basis of examinati and manner stated.	on and/or inv	restigation, in my o	pinion, deat	n occurred at the til	ne, date a	and place, ar	na aue to	the cause(s)
	With To t	Σ	29b. Signature and title of certifier	,		29c. Licens	e number	110	29d. [Date signed	(Month,	Day, Year)	
	(14bert / D	and my		Do	0141	CF		2/8/	106		
	MC		29b. Signature and title of certifier By Gut J B 30. Name and address of person who con Poblish J B AU 31. Date filed (Month, Day, Year) MAY 9 2006	npleted cause of death (Item	23a) (Type,	Print)	d m	KathNich	relle	and	206	19	
	2'		31 Date filed (Month Day Vear)	Manistrar's Signat	ure #	V111474	. ,,,,			/		(
	Sta Registr	ite ar	DAV Q 2006	registrat s signat	Apr								
	3,3,		MAI 3 2000	ACCOUNT OF THE PERSON OF THE P									

			For State Registrar	State of Maryla			of Health of Deat			giene Reg. No.	006	15758
4	A A		1. Decedent's Name (First, Middle, Las	t)	-				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Eric Orellana						April_	29,	2006	8:00 p M
1	Examin	_	4a. Facility Name (If not institution, give				own, or Location				inty of Death	
		S - 12 M	Holy Cross Hospi			Silv If Under 1	er Spr	<u> </u>	0.00.4014		ntgome	
W.	Funeral		5. Social Security Number 6. Se	9x 7. Age (In yrs M 2 F	s. last birthday) Yrs.		Days Hours	s Min.	8. Date of Birth (Month, Day April	/, Year)	9. Birth	
\$1.00	Director	}	None 'Ssual Residence of Decedent		0	U	0		April	21,200	o Hai	yland
	land		10a. State 10b. County	10c. 0	City, Town or Lo	ocation						10d. Inside City Limits
	Mary -f eh	to	Maryland Montgo	merv	Rockvi1	1e						1 X Yes 2 □ No
	r 28a	Directo	10e. Street and Number			10f. Zip C	Code			10g. Citizen	of What Cou	ntry?
	A with		4012 Heathfield	Drive		208	353			Unit	ed Sta	ites
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deceder	nt of Hispanic (Origin? (Spe	cify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White.	
ဖွ	or Ite		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 🏝 Yes 2 [110411, 010.7		ocify:	oic.
21215-0036	iral',	d by	3 Widowed 4 Divorced	Year or Dates:				El Sa	lvador	Lan	Othe	r Caucasian
2	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual kind of work DO NOT use	done durina m	ost of working	ng	16b. Kind o	f Business/In	dustry
2	within ne.	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		ne	retiredj			Non	0	
i T	filed within 72 hours after death with the Maryland Hygiene. uther then "netural", or Items 23s or 28s-f ehow with the Medical Exartral must be mulified at		17. Father's Name (First, Middle, Last)		- IVC	ine	18. Mo	ther's Name	(First, Middle,			
and	od of	Be	Carlos Benites				An		llana		,	
Ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itema 23a or 28a-f ehow entry fourther treumatic event, the Medical Exampler treumatic event, the Medical Exampler treumatic event, the Medical Exampler to the multified at once.	ပ	19a. Informant's Name/Relationship (1	Type, Print)	19b. Maili	na Address (/ Route Numbe	r, City or To	wn, State, Zij	Code)
Ma	d2s th an treu		Ana Orellana / M									nd 20853
ď,	Heal Heal		20a. Method of Disposition		. Place of Dispo	sition (Name	of of	The second second	ate		on - City or T	
<u>o</u>	ages ont of		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	te of H	-		¦ ₩₩ 5/5	/2006	Silv	er Snr	ing, MD
Baltimore, Maryland	nit. Partme ortan Injur		21. Signature of Funeral Service Licen						_			
Ba	Depar Impo		Ma S. G		Si	mple T	ribute	Funer	al and	Crema	tion C	enter nd 20852
4			23a. Part1. Enter the disease, of com shock, or heart failure. List only	plications that caused the de							mar y ra	Approximate Interval Between
*	Physician		fmmediate Cause (Final									Onset and Death
1	/Medical		disease or condition resulting in death)	a. Multiorgan Due to (or as a cons		е						2 days
	Examiner			Intracrani		orage						5 days
152		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons								
	outed od ransit	Examiner	that initiated events	c. Extreme Pr	ematuri	ty						8 days
o,	en ar		resulting in death) Last	Due to (or as a conse	equence of):							
8760,	icate be executed physicien and s the buriat-transit	Physician/Medical	•	d								
9	ntifica ing pl	Med	IF FEMALE:								1	
Вох	death certific e attending p id for use as I	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	⊒Ectopic pre				23d.	Date of deliv Month	ery Day Year
	the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	fdeath 5	Other (spec	cify)					
P.O	that the de led by the a detached		Part II. Other significant conditions of	ontributing to death but not r	esulting in the I	ınderivina caı	use given in Pa	ort I	23e. Did to	obacco use o	contribute to t	he cause of death?
ds,	e ig	Š	Tarrii. Other significant containers	on a back of the down back of the	oodiiing iii aloo	andony and occ	000 g.vo.ii ii i u			/es 2⊠N		bably 4 □Unknown
Records,	v requir been s should	Completed							24a. Was			
3ec	0 2 0	ig I					-		autop		prior to co death?	opsy findings available empfetion of cause of
H	ate Th								1 🗆 Yes	2 🖾 No	1 ☐ Yes	2 □ No
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:	D-20		Othor		(Check only o			
ō	Phys this ral di	5	1 Yes 2 X No	1 M Inpatient 2			1 40		ne 5 Resid			(y)
on	ding h. After funs	ig ig	1 ⊠Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	Injury	м	c. Injury at Work? 1 \sum Yes 2			1,		
S	Attending r death. ector: After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not b	e Ose Place of Injury At	t home, farm, si	reet, factory,	office	2			umber or Rur	al Route Number,
Division	after after Dire	erti	4 Homicide	building, etc. (Spe	icity)	•			City or Tov	vn, State)		
	Hospitel 14 hours a Funerel I	aic		ysician: To the best of my k								
	To the Hospitel or Attending in within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exar	niner: On the basis of exami and manner stated.	ination and/or in	ivestigation, i	in my opinion, o	death occurre	ed at the time,	date and pla	ce, and due t	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title obcertifier	0			License numbe			29d. Date sig	gned (Month,	
			1 Adold	but mo		1	7453	364		04	127/	06
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type	, Print)						
			Alan Goldberg, M		orest G		ad; Si	lver S	pring,	Maryla	and 20	910
	St Regist	ate	31. Date filed (Month, Day, Year) MAY 0 4 20	32 Registrar's Sig	nature	well						
26.70	negist	तवा	WIMI U # ZU	JUU KIRALI D								

		1	For State Registrar	State o	f Marylai		artment of H		nd Men		ene 0 0	6	157	59
			Decedent's Name (First, Middle, La	est)						Date of Death Month	Day	Year	3. Time of	f Death
3	Physicia /Medic			Mary	Bell P	ennock					15° 20	006	0115	АМ
	Examin		4a. Facility Name (If not institution, given	ve street and nu	mber)		4b. City, Town, o	Location of I	Death		4c. County	of Death		
			226 White Hall	Road			E1kton				Ceci			
	Funeral			Sex 1 □ M 2 🔯 F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. I	Date of Birth Month Day, 1	rear)	9. Birthp	lace (State of try) yland	or Foreign
	Director	-	216-24-6302 Usual Residence of Decedent	-X	77	118.				ol 31,	1920	Mai	yrand	
	and w	-	10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside C	ity Limits
	Mary f sho	ō	Maryland Cecil			E1kton							1 🗌 Yes	2 📉 No
	the 28a	Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of W	hat Cour	ntry?	
	3a or		~ 226 White Hall	Road			21921				Unite	ed St	ates	
	ms 2	Funeral	11. Marital Status		edent Ever in 1	U.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify	Yes or No-	14. Race		an Indian,	
9	or Ite		1 ☐ Never Married 2 ☐ Married	1 Tes	2 X No		1 ☐ Yes 2 X No	Specify:	r donto i nos	111, 010.)	Specify			
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show fre Madical Examirer aust be molitied at	Completed by	3 ₩ Widowed 4 Divorced	Year or D	ates:	1						Wh:	ite	
5-	"nati	lete	15. Decedent's E (Specify only highest gr			(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most o	of working	16	6b. Kind of Bu	siness/in	dustry	
12	withir ane. than	m	Elementary/Secondary (0-12)	College (1-4or 5+)		ner/Opera	•			Retai	1		
d 2	filed Hygid ther ant, I	e Co	17. Father's Name (First, Middle, Las	t)		- OW	iici / Opci c		s Name (Fi	rst, Middle, Ma	aiden Sumami			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan ff Health and Mental Hygiene. If Health and Mental Hygiene "natural", or Items 23a or 28a-f show flem 21 is marked other than "natural", or Items 23a or 28a-f show other treumatic event, I've Modical Examiner must be notified at	To Be	Joseph Hamilto	n Knox				Car	rie B	e11				
Ž	shoul nd Me mark mati	<u> </u>	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street				City or Town,	State, Zip	Code)	
Ma	ulth ar 27 is r treu		Lesley Smith/Da	aughter		1 Wal	ter Bould	len Sti	reet,	E1ktor	n, Mary	1and	21921	<u>L</u>
ē,	t Hea t Hea ttem othe		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of	e) M	lay 18	20	Oc. Location -	City or To	wn, State	
Ë	Page ent o nt: If ry or		1 X Burial 2 ☐ Cremation 3 {				natory or other place ce on Cemete	1	.006	•	herry F	Ii11.	Mary.	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after dea pepartment of health and Mental Hygiene. Importent: If Item 27 is marked other than "natural, or Items any injury or other treumatic event, It's Madical Examiner on page.		21. Signature of Funeral Service Lice	ensee -		H H	Name and Addre	1 4					-	(
Ö	Departiment of the poor of the		Donald	8. He	eler	1	03 W. Sto	ckton	Stree	et, Elk	ton, M	aryl	and 21	921
			23a. Part1. Enter the disease, or cor shock, or heart failure. List onh	nplications that	caused the dea	ath. Do not ent	er the mode of dyir	ng, such as ca	ardiac or re	spiratory arres	st,	165	Approximat Interval Bet	tween
	Physician		Immediate Cause (Final disease or condition	Ma	douter	tion &	Sarcun	~C~	-				Onset and	Death
	/Medical		resulting in death)	Due to	(or as a conse	equence of):								
1	Examiner		Sequentially list conditions.	b										
	P #	iner	Sequentially list conditions, it any, loading to infiltroduct cause. Enter Underlying Cause (Disease or injury	Dise to	(or as a conse	quence of):								
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conse	nuence of):						-		
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8760	ate hys the	dical		d										
9 X	leath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, ou	tcome of preg	nancy					23d. Date	of delive	arv	
Вох	death e atten ed for u	cian	23b. Was decedent pregnant in the past 12 months?		birth 2 ☐ Fe nant at time of		Ectopic pregnancy Other (specify)	1			Mor			Year
0	0 0 0	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkr										
٥	requires that the een signed by th nould be detache	y P.	Part II. Other significant conditions	contributing to o	leath but not re	sulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	cco use contri	ibute to t	he cause of	death?
Records,	uires r sign	d by								1 🗌 Yes	2 1 No	3 🗌 Prot	ably 4 🗍	Unknown
00	> 0 70	Completed								24a. Was an	24b. V	Vere auto	psy findings	available
Be	9 4 9	mo								autopsy performe 1 Yes 2	ed2 d	rior to co eath? □ Yes	mpletion of a	ause of
Vital	iclan: Th certificate ector, pag	a	25. Was case referred to medical	T				26. Place o	of Death (Ci	heck only one			26.110	
<u>></u>	S S	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2[☐ ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nurs	sing Home	5 Residen	ice 6 Othe	r (Specif	(y)	
οt		n: T	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o		y at			v injury occurre	ed		
0	atte	atio	1 Natural 5 Pending 2 Accident investigati	on				Yes 2 □ No	0					
Division	or Attendente of the offer death Director; in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	4 280. Plac	e of Injury - At ling, etc. (Spec	home, farm, sti	eet, factory, office		28f.	Location (Stree City or Town,	eet and Numbe State)	er or Rura	al Route Nun	nber,
	itel or irs efte rel Dir led in													
	Hospitel	Medicai	(Check only 2 Medical Exa	aminer: On the I	pasis of examin	nowledge, deat nation and/or in	n occurred at the tir vestigation, in my o	me, date and pinion, death	place, and occurred a	due to the cau It the time, dat	ise(s) and mai e and place, a	nner as s ind due to	tated. o the cause(s	s)
	To the Hospitel or Atte within 24 hours efter de To the Funerel Directo completely filled in by the	Med	one) 29b. Signature and title of pertifier	and mar	nner stated.		29c. Licens	e number		296	d. Date signed	(Month,	Day, Year)	
	F ≥ F 8		MIT	- d-	Y. V		N2	51.5	2		5/11/	60	Pages.	
	10		30 Name an address of person who	o completed cau	of death (In	em 23a) (Tvne	Print)				2 116/	ve	200	
_	10.		M 4/ //	ord, A	to 1	11 W +	Print) D3	Sto 1	04	Flkta	, ML) 2	192	./
4	Sta Reg <u>i</u> st		31. Date filed (Many), Day Year) 20	106	Registrar's Sign	nature	de							

MARY BELL PENNOCK

			Please	ype or Prin						•	
			For State	State of Ma	ryland / I		ment of F ficate of			71111	15760
			Registrar			Certi	iicale oi	Dealii	2. Date of Dea	Reg. No.	3. Time of Death
A.	Physici	an	Decedent's Name (First, Middle, Last		a D				Month MAY 13	Day Yea	
	/Medic		EDWARD LOUIS 4a. Facility Name (If not institution, give		SR.	4	b. City, Town, o	r Location of Death		4c. County of De	7:10 P
	Examin	er	CIVISTA MEDICAL				LAPLAT	Δ		CHARLE	'C
4	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h 98	irthplace (State or Foreign Country)
	Director		5/9-14-8431	MM 2□F	87	Yrs.	July 5	Tiodio iviai.		5,1919 W	
_	and *		Usual Residence of Decedent 10a. State 10b. County	-	10c. City, Tow	vn or Loca	tion				10d. Inside City Limits
	Maryli f sho	٥	MARYLAND CHARL	FC	MET	COME					1 ☐ Yes 2 XNo
	28a	rec	10e. Street and Number	110	AA TO TO	COME	10f. Zip Code			10g. Citizen of What	Country?
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show of cal Examiner must be notified at	Funeral Director	5775 COLD LAKE	DRIVE			206	93		U.S.	A .
	after death w or items 23a iminer aust b	ner	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Wa	s Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race - Ar Black, W	nerican Indian,
36	or It		1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give Year or Dates: W	0		Yes 2000	Specify:		Coocifu	
Ö	"natural", or ite	d by	3 X Widowed 4 □ Divorced			Dagadas	nt's Usual Occur	action		16b. Kind of Busines	WHITE
<u> </u>		lete	15. Decedent's Edu (Specify only highest grad	le completed)		(Give kir	d of work done NOT use retire	during most of wor	rking	TOD. KING OF BUSINES	samoustry
212	d with piene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		HEET	METAL	WORKER		JOHN FOR	RD CO.
þ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
<u>la</u>	Menta	5	WILLIAM HENRY	PAYNE			101	DELLA	FITEZ		
Maryland 21215-0036	12 should be filed within 7? h and Mental Hyglene. 7 le marked other than "n traumatic event, the Mass		19a. Informant's Name/Relationship (T)	/pe, Print)						r, City or Town, State	, Zip Code)
	ges 1 and 2 should be filed within to f Health and Mental Hyglene. If item 27 is marked other than or other traumatic event, the Mental trauma		EDWARD L. PAYN	E,JRSO	N 20b. Place of	-		LAKE DR	IVE, WI	ELCOME , MI 20c. Location - City	
ore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F		cemete	ery, crema	ony or other pla	ce)	Date	200. Location - City	or rown, State
Baltimore,	E 93 3		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	TILINO			CREMAT	ORY 5-1	5-06	ALEXANDRI	A, VIRGINIA
Ba	Departition Departition Importing any in ponce.		21. Signature of Furieral Service Licens	™ M0047	9	/ RA	YMOND	FUNERAL		CE, P.A.	
			23a. Part1. Enter the disease, or comp	lications (hat)caused t	the death. Do	not enter	PLATA the mode of dyir	, MARYI ng, such as cardiac	AND 200 or respiratory ar	546	Approximate
	Dhusisian		shock, or heart failure. List only of immediate Cause (Final	ne cause of each line	e. Icalce	0 100 11	,)				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a							aays
	Examiner		paragraphic like	Denvie	dean	m					days
0.	D .≒	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or sa	consequence			In a cold	mich		
ND	executed in and ial-transit	Examin	Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a	MUUL		NUCO -	nead/	ruin		gears
60,	o 9 5	calE	,	Due to (or as a	consequence	, ui).					
687	leath certificate b ettending physic I for use as the b			d							
Box (certil nding use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o						23d. Date of d	elivery
	death e ette	Iclai	in the past 12 months?	1□Live birth 2 4□Pregnan1 at t			ctopic pregnancy ther (specify) _	y 		Month	Day Year
P.O.	that the de ned by the e detached f	hys	9 🗆 Unknown	9□ Unknown					_		
S,	The law requires that the death certificate to has been signed by the ettending physbage 2 should be detached for use as the	by P	Part II. Other significant conditions co	ntributing to death but	t not resulting	in the unde	erlying cause giv	en in Part I.		4.1	to the cause of death?
ord	sen s nould	ted	Renu Insugu	Z					١٦١	es 2□No 3	Probably 4 Unknown
ec	law law las b	Completed	MYOCCHCUAY I	Schema	/ .			e)	24a. Was autop	sv prior t	autopsy findings available completion of cause of
<u>=</u>		S	Chronic Unshi	cove Pi	umoi	nuy	disea		perfo 1 Tes	med? death	es 2 No
Viti	vician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	Hospital:		(3)	3D DOA Ott	NOC.	ath Check only o		
o	ding Phyeician: n. After this certific funeral director,	. To	1 Yes No	Typ: Inpatien	nt 2 ☐ ER/O	Time of	3 DOA	4 Nuising F		ence 6 Other (Sport of the control o	necify)
on	ding th. : Afte s fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injui Wor M 1	rk? Yes 2 □ No		,,	
Division of Vital Records,	Attendi	ifica	3 Suicide 6 Could not be determined	288. Place of Injui	ry - At home, fo	arm, stree	t, factory, office		28f. Location (5 City or Tow	Street and Number or	Rural Route Number,
ā	s afte	Certification:	4 Formede	building, etc.	. (Зреспу)				City of You	ar, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier 1. Certifying Phy (Check only 2 Medical Exam	sician to the of	f my knowledg	ge, death o	ccurred at the ti	me, date and place	, and due to the	cause(s) and manner date and place, and d	as stated.
	the H in 24 the F	ledi	one)	front professor	ed.						
	Vill To Con	Σ	29b. Signature and title of centrier	111111	2		29c. Licens			29d. Date signed Mo	ini, Day, 1ear)
	110		- / K/A/	VIVV		· (T		46419		2/14/10	4
(141			omplied cause of us				TATTAM	A 2000 PM	***	
	Sta	ite	CHARLEN E. A. LETC 31. Date filed (Month, Day, Year)	HFORD , MD Registra	r's Signature	CITAL	1.05 51.	LAPLAT	H. 1111. 2.	040	Market III
	Regist		MAY 1 8 2008	Till at 12 a	H. A	Cool	2				

EDWARD C. PHYNE

DHMH 17 Rev 1/2001

Registrar

2 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1- State Registral MEND#23a(b/c)perMD5/4/06, BMW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 **Physician** 4 50 AM YONG 04 YON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □XM 2 □ F Hours Min. Director 212-82-2897 53 JULY 26, KOREA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other then "natural", or iteme 23e or 28e-f show eny injury copher traumatic event, the Madical Exercise. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits MONTGOMERY 1 ☐ Yes 2 X No MARYLAND WHEATON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11724 KING TREE STREET 20902 IISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 🖾 Divorced ASIAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PAINTER **METRO** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHONG KUN PYON SUN CHA LEE ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL PYON - SON 11724 KING TREE STREET; WHEATON MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN CEMETERY 4/24/2006 SILVER SPRING, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licensee Moelin 11800 NEW HAMPSHIRE AVE; SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Priysician /Medical Due to (or as a consequence of):

Liver Failure

ACRIBATION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed ettending physicien and for use as the burial-transit LIVER FAILURE Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Cher (specify) signed by the e d be detached for 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si shoutd 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 □ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 4 hours after deam.
Funerel Director: After this of many and the funeral director ٩ 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4-21-06 D0063738 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANJUMAN ARA, M.D. HOLY CROSS HOSPITAL SILVER SPRING, MD 31. Date liled (Month, Day, Year) 32 Registrar's Signature State Registrar 04 2006

			For State Registrer	State o	f Marylar		artment of			lental Hyg	iene	06	15763
			1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Jung	Yea		P	ark			May 1,	2006		2:50 p M
	Examin		4a. Facility Name (If not institution	n, give street and nu	nber)		4b. City, Town	, or Locatio	on of Death		4c. County	of Death	
т			8025 Invernes	s Ridge R	oad			otomac			Mont	gome	ry
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 K F	7. Age (In yrs.		If Under 1 Ye Months Day		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
	Director		207 62 8068	1 M 2 L	71	Yrs.				Nov. 27		K	orea
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
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	er de	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Fo	rces?	J.S. 13.	Was Decedent of If Yes, specify C	uban, Mexic	can, Puerto	Rican, etc.)		k, White,	
36	rs aft	by F	3 ₩ Widowed 4 Divorced	If Yes, Gir	/8		1 ☐ Yes 2 🛣 N	lo Speci	ify:		Specify	Asi	an
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D	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then ineturel; or Items 23s or 28s-1 show or other then ineturel; or Items 23s or 28s-1 show event, the Medical Evair included at	Be C	17. Father's Name (First, Middle,	Last)				18. Mo	ther's Name	(First, Middle, i			
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2	S E E	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre	et and Num	nber or Rura	l Route Number	City or Town,	State, Zip	Code)
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ē,	s 1 a if Hei item othe		20a. Method of Disposition			Place of Dispo	osition (Name of matory or other p		inge m	ate	20c. Location -	City or To	wn, State
Ē	Pagas nent of ant: If it		Gurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from	State		[emorial		5/5/0)6	Olney,	Marv	1 and
Baltimore,	parmit. Pagas Department of Important: If it any injury or once.		21. Signature of Funeral Sirvic	/	1					s Rinal			
ñ	Par Imp	17	Atura !	Soulo	V.								, MD 20904
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	2		30 Name and address of person	who completed caus	e of death (Ite	т 23а) Туре,	Print)	1	1/0	DiLa	0 101	ni	1,120852
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			For State Registrar	State of Maryla		artment of F rtificate of			giene 2	006	15764
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1	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Dea	ith	- 1	nty of Death	
		~	PENINSULA REGIONAL	Medical C	eNTU	340	ister		1	Kosmi	co .
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If User 24 Hr Hours Mir		th V Yearl	9. Birthp	lace (State or Foreign
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ŏ	within 72 hours after death with the Maryland ane. than "natural", or Items 23s or 28s-f ehow in Madical Examinar must be notified at	ed	15. Decedent's Educ	ation	16a. Deced	dent's Usual Occup			16b. Kind of	Business/Inc	dustry
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/lai		2	Raymond Peters				Wanda :	Blodgett			
an	2 should and Men Is marke raumatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Numbe	er, City or Tow	vn, State, Zip	Code)
Σ	D 높 C 분		Geneva J. Peters			The second secon	Berlin,	MD 21811			
Baltimore, Maryland 21215-0036	0 O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, cren	sition (Name of natory or other plac	сө)	Date	20c. Locatio	n - City or To	wn, State
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at	permit. I Departm Importal eny Inju		21. Signature of Funeral Service License	0	22	. Name and Addre	ss of Facility	The Burba	ge Fun	eral F	lome
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			23a. Part I. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de e cause on each line.	ath. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory ai	rest,		Approximate Interval Between
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Division	or Attending Physician: after death. Director: After this certific in by the funeral director,	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, str			28f. Location (5	Street and Nur	nber or Rura	l Route Number,
Ë		Certification:	4 Homicide	building, etc. (Spec		201, 1001019, 011100		City or Tou			
	To the Hospital within 24 hours and the Funeral completely filled		29a. Certifier Certifying Phys	ician: To the best of my k	nowledge, death	occurred at the tir	ne, date and plac	e, and due to the	cause(s) and r	manner as st	ated.
	Me Ho	Medical	one) 2 Medical Examin	er: On the basis of exami- and manner stated.	nation and/or inv	estigation, in my o	pinion, death occ	curred at the time,	date and place	e, and due to	the cause(s)
	To the Ho within 24 Protection To the Fu completely	ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ned (Month, L	Day, Year)
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			30. Name and address of person who con	npleted cause of death (It	em 23a) (Type,	Drint)					100000000000000000000000000000000000000
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	,			,		
	Regist	rar	MAY 0 5 201	Jb Diese	N. A.	and I					

Sherrill Peters 533-58-6567

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Christina M. Quesenberry Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/l Month D May 5, 2006 2002 hrs Medical Examiner Christina Marie Quesenberry 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Leonardtown St. Mary's St. Mary's Hospital If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Director Country) 212-31-9633 1 M 2 X F Yrs 8/05/1988 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits any 10a State 10b County 1 Yes 2 X No 28a-f show : 23a or 28a-f show : notified at once. Mechanicsville Director Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37796 Beverly Drive 20659 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funera 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year 1 Yes 2X No specify: Widowed Divorced Specify: White <u>≨</u> 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Compl High School 11 Student 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Robert Christopher Quesenberry Tammy Lee Cline Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37796 Beverly Dr. Mechanicsville Maryland 20659 Tammy Quesenberry / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/11/2006 Leonardtown, MD. Charles Memorial Donation 5 Other Specify: 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licenses 22955 Hollywood Rd. Leonardtown, Maryland 20650 Kyle S. Simons M01206 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itlated Due to (or as a consequence of): events resulting in death) Last and Physician/i/ledical UNPENDED AMENDED ending physician use as the burial -The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other _ Nursing Home 5 Inpatient 2 V ER/Outpatient 3 LDOA this Residence 6 1 🗸 Yes 28a. Date of Injury FOUND: Day, Year) After 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death Driver auto auto collision 1 Natural FOUND: 1 Yes 2 ✓ No Director: d in by the f Pending after death May 5, 2006 0000 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Maddox Rd./Notley Hill Rd., Chaptic, Md. determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. May 6, 2006 lame and address of person who completed c use of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore King MD. 31. Date filed (Month Registrar's Signature Day State 2006

ORIGINAL

Registra

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rivers Year **Physician** Month 20:19 PM Richard 2006 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins HOSPITAL Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Hours June 9. 63 1942 Director 467-64-0388 Texas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 No D.C. None Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20007 4809 V Street, N.W. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after o Det autment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or item any injury op other traumatic event, tra Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ White 3 ☐ Widowed 4 🛣 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lawyer International Trade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stewart Robinson Rivers Fiske Madge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4809 V Street, N.W. Washington, D.C. 20007 Laura Ellen Rivers / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State May 5, 2006 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc., Cles Comprile 5130 Wisconsin Ave., N.W. Washington, D.C. 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner failure I'm onth renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien and thed for use as the burial-transit 2 year S The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence Inpatient 2 ER/Outpatient 3 DOA ို 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Certification: Injury at Work? 5 Pending investigation 1 Tyes 2 No 2 Accident Director: 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerei 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30,2006 20 Mathelier, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore Maryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Registrar

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Della Riley 2006 15:46 M May 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21X F Director 578-26-5850 93 Nov.27, 1912 South Carolina Usual Residence of Decedent with the Maryland 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other treumatic event, the Madical Exprinter must be notified at ones. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 XYes 2 No Directo Maryland Prince Georges Clinton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10300 Thrift Rd. 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black ģ Specify: 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Bell Dinah Belton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10300 Thrift Rd. Clinton, Md. Jimmie L. Rilley / Son 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial May 5, 2006 Landover, Md. 21. Signatury of Funeral Service Line see 22 Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Marlboro Pike/Forestville, Md. 20747 Part 1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Chronic obstructive lung Disease **Physician** 10 4. /Medical Due to (or as a consequence of) Examiner 2 Weller f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Poper monia Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 \(\text{Yes} \) 2 \(\text{No} \) No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death signed by the al 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 200 No Division of Vital i or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2≅ No ۴ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 SNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > M Sido 065365 05-01-2006 5 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) livingston RU 4 (0) fort washington MA 207 46 Michael Sidarous MA. 11701 31 Date filed (Month, Day, Year) MAY 0 4 2006 32. Registrar's Signature State Registrar

		•	1 - State of Maryland / E	Department of Hea Certificate of De			ene 2006	15769
	0 , ;		Decedent's Name (First, Middle, Last)			Date of Death	Day Year	3. Time of Death
	Physicia /Medic		Marie Mabel Murray Robinson				0, 2006	9:45 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	ation of Death		4c. County of Death	
			St. Thomas More Nursing Home	Hyattsvill			Prince Geo	orge
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Months Davs Ho	lours Min. (Date of Birth Month, Day, Y	(ear) 9. Birthpi	ace (State or Foreign try)
	Director		577-34-8312 93	Yrs.	Ma	rch 17	,1913 Vir	ginia
	and W	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location			11	Od. Inside City Limits
	faryli eho	5	DC Washin	gton				M∑Yes 2 No
	28a-	Director	10e. Street and Number	10f. Zip Code		100	. Citizen of What Coun	trv?
	with le or		214 Divison Avenue N.E.	20019			nited State	
	ns 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispar	nic Origin? (Specify	Yes or No-	14. Race - Americ	
"	fter c	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ♣ No	If Yes, specify Cuban, M		n, etc.)	Black, White,	
93	el'.o	by	3X Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Sp	pecify:		Specify: Blac	2k
2-0	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-f ehow cuited Exatribet must be notified at	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation	n na most of working	16	b. Kind of Business/Inc	ustry
21	c * 3	nple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during life. DO NOT use retired)		_		
7		Co	OLD THE	usewife			omestic	
Maryland 21215-0036	o d to D	Be	17. Father's Name (First, Middle, Last)	1	Mother's Name <i>(Fir</i>	_{st, мідоїв, ма} Se 1b y	iden Sumame)	
yla		ပ္	Josh Ray Murray					
Jar				. Mailing Address (Street and I 010 Peartree I			ryland 207	
	is 1 and 2 of Health a item 27 is other trai		marze ereci, regis		Date		c. Location - City or To	
Ö	0 0		1X Burial 2 Cremation 3 Removal from State	Disposition (Name of ry, crematory or other place)	5/5/20		Linton, Mar	
ţ	t. Pa tmen tent:		- Contains a Contain (opening)	rection Cem.				yland
Baltimore,	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee	Alexander 5. 5538 Marlbore	o Pike Fo	restvil	lle, Maryla	nd 20747
			23a. Part 1 Inter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, su	uch as cardiac or res	piratory arrest		Approximate Interval Between
	Pnysician [®]		Immediate Cause (Final disease or condition	evote laud	100 vas G	1900	wegite.	Onset and Death
	/Medical- Examiner		resulting in death) Due to (or as a consequence					1
	- xammer		Sequentially list conditions, b.					
	be sit	Examiner	any, leading to immediate cause. Enter Inderlying Cause, (Disease or injury	JTJ:				
	and -tran	каш	that initiated events resulting in death) Last C	of):				
8760,	cate be executed oblysician and the burial-transit		5 5 5 6 70 45 45 4 5 6 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7	J.,				
87	physi physi s the t	dica	d					
9 X	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of delive	D.
Вох	atten for u	cian	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				Day Year
o.	at the de by the a tached	ysie	1 Yes 2 No 9 Unknown					
Q	res that signed by be deta		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in	Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
ds	uires I sign Id be	q p	Dementra			1 ☐ Yes	2 ☑No 3 ☐ Prob	ably 4 Unknown
200	v requir	Completed by	Renal mass			24a. Was an	24b. Were autor	osy findings available
Re	The lav	m				autopsy performe	d?/ prior to con death?	npletion of cause of
a		e Co	25. Was case referred to medical	26	. Place of Death (Ch		No 1 □ Yes	2 L No
of Vital Records,		80	examiner? 1 ☐ Yes 2 ☐ No	Other	-		ce 6 ☐Other (Specify	1
	Phy or this eral di): To	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injury at			injury occurred	/
On	nding Phy th. : After thi e funeral o	to	1 ☐ Watural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation		2 🗆 No			
Division	l or Attending after death. Director: After	Hice	3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, office	28f. I	ocation (Street	et and Number or Rural	Route Number,
Ö	a afte	Certification:	4 Homicide determined building, etc. (Specify)		'	City or Town, S	3(4(0)	
	To the Hospitel or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	al (29a. Certifier 1 Certifying Physician: To the best of my knowledge					
	To the Ho within 24 I To the Fu completely	edical	(Check only 2 Medical Examiner: On the basis of examination are and manner stated.	icuor investigation, in my opinio	on, death occurred at	ine time, date	and place, and due to	tne cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License nur			. Date signed (Month, L	
			Vaullen Worl in	X 1018	552	Z	MAYZE	OF
D	(10)		30. Name and address of person who completed cause of death (Item 23a)	(Type Print) Overeus 5	00	M	173.711.11	A 2000
1	19		PAUL A 180 VORE MY 4238	Chosens 20	my cl	1199	45-117	73 -0.0
: 1	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	had i				
8	Regist	ar	MAY 0 4 2006		_			

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Jennifer Marv Smith 1:40 рм May 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2√2 F 212-66-8475 50 Yrs. 6, Sept. Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12207 Braxfield Court 20852 USA filed within 72 hours after death 14. Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify: White 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 → Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Caterer Catering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be file partment of Health and Mental Hy portant: if Item 27 is marked oth y Injury or other traumatic event ca. Be Ronald Smith Ann Jennifer Catania 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Sierra Del Norte, Fort Pierce, FL 34951 Ann Jennifer Bogley/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 2006 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Function Service Licenses Francis Addess Coillyins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Coberton a 23a. First. Enter the disease, or complications that caused the duath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Subarachnoid Hemorrhage /Medical Due to (or as a consequence of): Examiner Intracerebral Hemorrhage S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Anterior Communicating Artery Aneurysm Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4-Unknown Liver Cirrhosis, Gastric Ulcer, Esophageal Varices, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Alcohol Abuse, Pancreatitis, Bacteremia, mpeo. 2⊟ No 1 ☐ Yes Hemorrhagic Anemia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛂 No Certification: To 27. Manner of Death t²□Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the f 2 Accident investigation 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43691 May 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4927 Auburn Avenue, Bethesda, MD 20814 Alexandros Powers, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

DHMH 17 Rev 1/2001

2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Kell 7:57 PM Sharm 6, 12 2006 144 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPHa 114 The Johns Hopkins timore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Jul 6, 1951 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ F Yrs. MD Director 201-42-5466 54 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatilt and Mental Hygiene. In the fitten 27 is marked other then "natural" or Items 23a or 28a-f show mit: if item 27 is marked other then "natural" or litems 24 or 18a-f show any or other treumatic event, the Medical Evanting matrix to clitical any or other treumatic event, the Medical Evanting the matrix and any or other treumatic event. 10a State 10c. City, Town or Location 10d. fnside City Limits 10b. County il Hygiene. I other then "natural", or Items 23a or 28a-1 sinom ivent, the Medical Evandmet must bu multiflad at MD Allegany Cumberland Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 538 Fort Avenue 21502 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 ☐ No If Yes, GiveX Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No 21215-0036 Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer Correctional Institute 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Dorothy Grace (Sullivan) Trump Clarence Trump, Jr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 Kenneth Hedrick fiance 538 Fort Avenue Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 5/17/2006 Sunset Memorial Park MD Cumberland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a/Parl. Safet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): **Examiner** austro ivite ING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducito (or as a sonsequence of). Physician/Medicai Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Box 68760,8 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by TIMACISH erosima 1 Yes Mo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes o the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No ٩ SIU! Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Medical Ductor Res-000

Registrar

31. Date filed (Month, Day, Year)

1 8 2006

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32. Registrar's Stanature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bulchwin The Johns Hopkins Huszit

			1 - For State Registrar	State of M	aryland	/ Depa	artmer rtifica:	nt of H te of L	ealth a Death	and M	ental Hy	giene		6	15	772
横点			1. Decedent's Name (First, Middle, La	st)							2. Date of De	eath Da	y Yea	20	3. Time of	Death
*	Physic / /Media		Sue Marine	Singer							May	10			5:00	O PM
	Examir		4a. Facility Name (If not institution, giv				4b. City	Town, or	Location o	of Death	1	4c.	County of D			
137		14F	Frederick M	emorial.	Hospi	tal	If I lade	Fre	deri If Under 2	ck					rick	
	Funeral Director		5. Social Security Number 6. S	M 2∭ F	je (In yrs. lasi	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, D.	ay, Year)		Countr		_
	36		228-28-3226 Usual Residence of Decedent		81					J	May 4,	192	o we	St	Virgi	nıa
Z	how at		10a. State 10b. County		10c. City, T	own or Lo	cation							10	d. Inside C	´
Z	a-f.s	ctor	Maryland Frederic	k	Frede	rick									1 🗌 Yes	2 🔼 No
ŧ	or 28	Directo	10e. Street and Number				10f. Zi	o Code				10g. Cit	izen of What	Countr	y?	
- Co	238	rai	6351 Spring Ridge				217					USA				
an de	ltem Der m	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅		13.	Was Dece If Yes, spe	dent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Al Black, W			
36	,04	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	140		1 🗌 Yes	2 X) No	Specify:				Specify: Wh	nite	2	
21215-0036 ad within 72 hours after death with the Maryland	atura ical		15. Decedent's E		1	6a Dece	dent's Usu	al Occupa	ition	. of works		16b. K	ind of Busine			
216	Mai.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT L	ise retired,	luring most)	OF WORK	ng					
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pue 2	od otl	Be	17. Father's Name (First, Middle, Last)							(First, Middle	, Maiden	Sumame)			
Maryland	d Mer nark	T ₀	Jernon Craig 19a. Informant's Name/Relationship (Type Print)		10h Mailir	a Addros		Minni		1117 I Route Numb	or City o	r Tour State	o Zio C	anda)	
Z S	th an 27 is trau		R. Alex Marine, s				•				own, M		1788	s, 210 C	,00e/	
ē.	itam 27 is other trac		20a. Method of Disposition		20b. Plac					-	ate		cation - City	or Tow	n, State	
OL S	nt: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Con							5/12/	2006	Smit	hsburg	. M	arv1a	and
Baltimore,	Department of Health and Mental Hygiene. Important: If item 23a or 28a-1 show any injury or other traumatic event. The Medical Examinar must be notified at ance.		21. Signature of Funeral Service sice		Diaz es		_				ney and					
m a	Pepa Impo		HUM MEST	Gen	M009	221					et, Fr					
Ε	hysician /Medical xaminer	ner	23a. Part. Enter the disease or composition of the	a. Due to (or as	a consequent	CHNO ice of):					,			1	Approximat nterval Bet Onset and I	ween
68760,	the attending physician and ned for use as the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequen	ice of):										
O. Box (ed by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ M6 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3[Ectopic p Other (s	regnancy pecify)					23d. Date of o			fear
ecords, P.O	been signed t	ρ	Part II. Other significant conditions of	contributing to death b	out not resultin	ng in the u	nderlying	ause give	n in Part I.				ise contribute ⊋√lo 3 □	_	cause of d	
<u> </u>	ate h	Completed								_	24a. Was auto perfe 1 \(\text{Yes}		24b. Were prior to death	o comp	y findings a pletion of ca No	available ause of
of Vita	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Ort -			(Check only					
Division of	h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Outpatien b. Time of Injury		28c. Injury Work	4 🗆 1401	2	ne 5 Res 28d. Describe			pecify)		
Divisi	를 를 드	Certification:	3 Suicide 6 Could not be determined	Zoe. Flace of m	iury - At home c. (Specify)	, farm, str	eet, factor	y, office		2	28f. Location (City or To	Street an wn, State	d Number or)	Rural I	Route Num	ber,
]	in 24 hours in 4 hours in 54 h	edicai	29a. Certifier 1 Certifyin, Pt (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis o and manner st	f examination	dga, dalah and/or inv	vestigation	it the time i, in my op	e, date and inion, deat	th occurre	ind due to the ed at the time,	rdusa(s) date and	and manner place, and d	at stat lue to ti	eu. he cause(s)
	within 2 To the	Σ	29b. Signature and title of certifier					c. License	a	n		29d. Dat	e signed (Mo	nth, Da	ay, Year)	
			Scherce	m			B	1196	140	10		5/1	11/06			
	4		30. Name and address of person who	completed cause of c	leath (Item 23	За) (Туре,	Print)	DPR	(1	Men	mal to	copy	W R	21-2	Die	
100	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 8 20	Registr	ars Signature	Aça	Med .					9				

		1 - For State Registrar	State of Mar		artment of Horificate of L		Re	g. No. UUt	15773
Physic		Decedent's Name (First, Middle, Last Ralph T	" homas	Skelley			2. Date of Death Month May 12,	Day Year	3. Time of Death 23:45 M
/Medi Examii		4a. Facility Name (If not institution, give	street and number)	Choncy	4b. City, Town, or		.v.u, 12,	4c. County of De	
		12701 Valley View 5. Social Security Number 6. Se		(In yrs. last birthday)	Cresapto	If Under 24 Hrs.	8 Date of Birth	Allegany	irthplace (State or Foreign
Funeral Director			7	87 Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, Jul 3, 1	918 N	ND (Supply)
and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
a-f sh	ctor	MD Allegar	ny	Cres	aptown				1 □ X es 2 □ No
72 hours atter death with the Maryland natural', or items 23a or 28a-f show alsoi Examiner must be notified at	Funeral Director	10e. Street and Number	Avanua		10f. Zip Code	21502	10	og. Citizen of What C USA	Country?
ms 23	neral	12701 Valley View	12. Was Decedent Ev	rer in U.S. 13.	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-	14. Расе - Ап	nerican Indian,
be filed within 72 hours after death with the Marylan nat Hygiane. Idea Hygiane. Idea other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the M. or all Examiner must be notified at	d by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ ₩idowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	wwii	1 ☐ Yes 2 ☐ No	Specify:	rican, etc.)	Specify: W	hite .
n /z ii i "natu i dical	Completed by	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work	ing	16b. Kind of Busines	s/industry
giane grane or than	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	Polish	,		F	PPG Indus	tries
inould be filed id Mental Hygi marked other matic event,	To Be (17. Father's Name (First, Middle, Last) Ralph B. Skelley	1			18. Mother's Name		Maiden Sumame) e) Skelley	
Ith ac 27 is 27 is		19a. Informant's Name/Relationship (7) Linda Grant	ype, Print) daugh		ng Address (Street a. 01 Valley \	nd Number or Rura /iew Ave	al Route Number, Cresa		MD 21502
00		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify		20b. Place of Disponentery, cre Rocky Gap	osition (Name of matory or other place Veterans' Co)	5/15/2006	Plintstone	
permit. Pag Department Important: I any injury o		21. Signarure of Furieral Price Licent	J. Day	SQ - 2	2. Name and Address Scarpelli 108 Virg			and, MD 215	02
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that ceused in one cause on each line	ne death. Do not en					Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Manin	< Color	1		0	shoul Sue
Examiner		f	Due to (or as a	consequence of):					
Si s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se s	noneequation offic					
al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
ficate be executed physician and is the burial-transit	dicai		d						
ath certi	Physician/Med	in the past 12 months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d	elivery Day Year
the d y the	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
law requires that es been signed b 2 should be deta	by	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	inderlying cause give	n in Part I.	23e. Did tob		to the cause of death? Probably 4 Unknown
ete h page	Completed						24a. Was ar autopsy perform 1 Yes 2	24b. Were a prior to death?	autopsy findings available completion of cause of s 2 \(\sum \) No
Physician: Th this certificete ral director, pag	9 Be	25. Was case referred to medical examiner?	Hospital:	0 = 500 · · · · · · · · · · · · · · · · · ·	Othe	26. Place of Death	1/	*****	
g Physical dispersal di	n: To	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time o	nt 3 DOA	4 Nursing Ho	- 1-	nce 6 Other (Sp w injury occurred	ecify)
Attending In death. • ctor: After by the funer	catio	t Anatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □ Y	es 2 □No			
	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or I , State)	Rural Route Number,
	Medical	29a. Certifier (Check only one) Check only one)	ysician: To the best of iner: On the basis of e and manner state	xamination and/or in	th occurred at the time evestigation, in my op	e, date and place, inion, death occurr	and due to the ca red at the time, da	iuse(s) and manner at and di	as stated. ue to the cause(s)
To the Comple	Σ	29b. Signature and title of certifier	*		29c. License		29	9d. Date signed (Moi	nth, Day, Year)
1		30. Name and address of person who o	completed cause of dea	ath (Itam 23a) (Tues		26907		11ay 12	dUG
3		Harii. Sidhu M.D		925	Bishop Wa	Ish Road	Cumbert	and MD 21	502
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	W				
negisi	al	MAY 1 8 2006	JACKET .	- 17					1

DHMH 17 Rev 1/2001

isk per Randy Brooks

		4	For State Registrar	State of Ma	•		artment tificate			ind M		giene Reg. No.	06	15774
	Dharisi		1. Decedent's Name (First, Middle	a, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
П	Physicia /Medic	_	Larry	Reginald	9	Str					April	29 2	006	6:30 a ^M
	Examin		4a. Facility Name (If not institution	-				- 1	Location of				ity of Death	
			1290 Ammendal		(In our land him	the effect of	Mi.		svill If Under 2		8. Date of Birt		e Aru	
	Funeral Director		5. Social Security Number 302-34-6759 Usual Residence of Decedent	1 XM 2 F	(In yrs. last birt	Yrs.	Months	Days	Hours	Min	(Month, Day Sept. 2	9,1939	Ind	place (State or Foreign ntry) 11ana
	Aaryland I ehow	ō	10a. State 10b. County	Arundel	10c. City, Town									10d. Inside City Limits 1 ☐ Yes 2X No
	28e	rect	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cou	intry?
	N with	0	1290 Ammendale	Court				21108	3			US	A	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I have said other then "natural", or Iteme 23a or 28e-f show aumatic event, the Medical Examinar must be nightled at aumatic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	If Yes Give 4		1	Was Deced 1 Yes, spec		panic Orig , Mexican, Specify:	jin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. R: Bi	ack, White	ican Indian, , etc. hite
21215-0036	thin 72 ho le. en "natur Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give life. L	dent's Usua kind of wor DO NOT us	k done di	urina most	of workir		16b. Kind of		·
7	ed wi	S		4	Lin	ngu:	ist		40 14-4-	40.810.000		Dept.		fense
Maryland		To Be	17. Father's Name (First, Middle, Robert H. Stro								(First, Middle, Golder		ame)	
2	nd 2 sho eith and I 27 ie mu		19a. Informant's Name/Relations Jane B. Strong				•				Route Numbe Millers			
Baltimore,	ages 1 a ant of Her it: If Item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 4 ☐ Donation 5 ☐ Other (S		20b. Place of cemeter Metro				1	5-2-	ate 2006	20c. Location	•	
Baltir	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic ex <u>once</u> .		21. Signature of Funeral Service		Metro		Name and	d Address	of Facility Fune	ral	Home, F d, Gamb	P.A.		
	Physician		Immediate Cause (Final	r complications that caused to only one cause on each line	he death. Do r	not ent	er the mode	e of dying	, such as	cardiac o	r respiratory ar			Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence	of):	٠٠٠	01	Ne Be	do	47			
	cuted nd ransit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a a c.	consequence	of):		X			./			
8760,	rificate be executed ng physiclen and as the burial-transit	icai	resulting in death) Last	d	consequence	of):								
P.O. Box 68	death cer e ettendir ed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. Il yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death]Ectopic pro] Other (spe						Date of deliving	eery Day Year
	uires that I signed by Id be deta	Ď	Part II. Other significant condition	ons contributing to death but	t not resulting in	the u	nderlying ca	ause give	n in Part I.			bacco use co		the cause of death?
Records,	Physician: The law requires that the this certificate hes been signed by the fall director, page 2 should be detached.	Completed									24a. Was autop	rmed2	prior to co death?	opsy findings available ompletion of cause of
tai	Ifficet	0	25. Was case referred to medica	1					26 Place	of Death	(Check only o	2- No	1 🗆 Yes	2 □ No
<u> </u>	ysici is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	t 2 EFVOu	tpatien	t 3 DO	Othou	p-		ne 5 - Resid		ther (Speci	fy)
Division of Vital	Attending Ph ir death. ector: Alter th by the funeral		27. Manne Death 1 Natural 5 Pendir 2 Accident Investi	28a. Date of Injury (Month, Day igation	Yeer) 28b. 1	lime of njury	M 2	8c. Injury Work 1 🗆 Y	at ? 'es 2 □ N		8d. Describe h	now injury occi	urred	
Divis	in Life	Certification:	3 Suicide 6 Could 4 Homicide determ		y - At home, fa (Specify)	rm, str	eet, factory	, office		2	281. Location (S City or Tow	Street and Num m, State)	nber or Rui	al Route Number,
	To the Hospitel within 24 hours a To the Funerel completely filled	edicai (29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best of Examiner: On the basis of and manner stat	examination an	death d/or in	occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, a h occurre	and due to the ded at the time, d	cause(s) and r date and place	nanner as	stated. o the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifie	Ti A	122:	h	29c	. License	number	06		29d. Date sign	ned (Month,	Day, Year)
			30. Name and address of person	who completed cause of de	ath (Item 23a)	Type,	Print)	0)	11	1			100	
	Sta	ite	31. Date filed (Month, Day, Year,	777/5, MD	900 / 's Signature	505	7341	- /	P	117	napol	15	MB	71401
· Bu	Registi		MAY 0 3	200b A	· K	100	de							

			For State Registrer	State of Maryl		artment of F			Reg. No.	06	15775
-	Dhusiai	3.	1. Decedent's Name (First, Middle, Las)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Lillie Ma	rie	Suit			April		006	5:00 p ^M
1 .	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o		Death	4c. County		
		×.,	Genesis Eldercar			Annapo		U-s C		Arun	
	Funeral Director		224-34-9777	744 0777	yrs. last birthday, 75 Yrs.	Months Days		Min. (Month, Da	y, Year) 4, 1930		lace (State or Foreign htry) th Carolina
	and *		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10	0d. Inside City Limits
	danyl f sho	ō	MD Anne Aru	nde1	Annapo1	ic					1 ☐ Yes XX No
	28a	rect	10e. Street and Number	ilder	Amapoi	10f. Zip Code			10g. Citizen of	What Count	itry?
	3a or	0	35 Milkshake Lan	e		214	401		USA	4	
	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show disal Evant art must be codified at	Funeral Director	11. Marital Status	12, Was Decedent Ever	in U.S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		e - America	
9	after or its	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2XXNo		1 ☐ Yes 2 XNo		ruento rican, etc.)		ck, White, e	nite
8	rai', c	i by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		1 105 2LANO	Зреспу.		Specif	/: WI	1116
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Madical Examinar must be collised at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done	during most o	of working	16b. Kind of 8	usiness/Ind	lustry
2	within ene. than "	ф	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	•				
2	e filed within al Hygiene. I other than " vent, the Me		12		Divi	sion Mana		s Name (First, Middle,	Sears		
밀	be fill	Be	17. Father's Name (First, Middle, Last)						Maiden Suman	10)	
Z	s 1 and 2 should be f Health and Menta item 27 is marked other treumatic ev	2	Louis McGee	Orien)	105 14-0	Add /Canad		e Taylor or Rural Route Number	or City or Tour	Ctata 7/a	Codol
Ja	l 2 sh and rism rism		19a. Informant's Name/Relationship (7) Donna S. Ruhsam			-					C00e)
	s 1 and of Health item 27 other to		20a. Method of Disposition					dgewater,	20c. Location		wn. State
Baltimore,	ges at of h if its or of		1 ☐ Burial 2 XCremation 3 ☐	Memoval Irom State		osition (Name of imatory or other place				•	
Ë	t. Pa rtmer rtant rjury		4 □ Donation 5 □ Other (Specify 21. Signature of Toner: Service Licen		Metro Cr			2-2006	Baltimo	re, M	ID
Bal	permit. Pages Department of Himportant: if ite any injury or of gnes.		Talmi A	ardall	2	Hardesty 12 Ridge	Funer	al Home, I	P.A.	m 214	101
8760,	Physician /Medical Examiner of the prival-transit of the prival-tr	ical Examiner	23a. Part 1. Enter the disease of compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	nsequence of):	diseo	je				Interval Between Onset and Death
P.O. Box 687	death certifi e attending ed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pr 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc: □ Other (specify) _		aza Dist	Mo		Day Year
Records,	The law requires that the ste has been signed by th pege 2 should be detacht	þ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the I	underlying cause giv	ven in Partt.		Yes 2 □ No	3 Proba	ne cause of death?
Ö	w requ been shoul	Completed						24a. Was	an 24h	Were autor	psy findings available
Rec	The lav	E						auto	psy ormed?	prior to con death?	mpletion of cause of
<u></u>		e Co	25. Was case referred to medical				00 50	1 Yes		1 🗆 Yes	2 No
Vital	<u>⊇</u> 8 €	m	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	ent 3 DOA Ott	000	of Death <i>(Check only only of Death (Check only of Death (Check only of Death only of Death only of Death (Check only of Death only of Death (Check only of</i>		apr /Specifi	re)
of		n: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye					how injury occur		7
<u>ö</u>	nding ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation		ar) Injury		Yes 2 □ No	0			
Division	il or Attending after death. Director: Aftei d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s	treet, factory, office		28f. Location (City or To		oer or Rural	l Route Number,
	To the Mospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C		ysicien: To the best of my niner: On the basis of exa and manner stated.							
	To the within To the comple	Me	29b. Signature and title of certifie			29c. Licens	se number		29d. Date signe	d (Month, L	Day, Year)
	~ \$ F 0		D 45///			D38	958		5/1/0	6	
7			30. Name and address of persop who	completed cause of death	(Item 23a) (Type				' (
			Da Pipit Sin	4 L Cull	208	Crain	Hist.	10. SW 1	Clin Bu	VNIA 1	MD 21061
10	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Sand s	0	J	Opre : C. M.		y way

		•	for State Registrar	State of M	arylan		artment of I			•	giene Reg. No.	005	157	176
			1. Decedent's Name (First, Middle,	Last)					1	2. Date of De	ath	V	3. Time of	Death
	ysicia Iedic		0dell	Martin		Sn	nith			Month May	1 200	6 Year	0937	М
	amin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town,	or Location	of Death		4c. Cou	nty of Death	1	
			Genesis Elderc	are - Spa C	reek		Annapo				Ann	e Aru	ndel	
Fund	eral			6. Sex 7. Ag 1 🔯 M 2 🗆 F		last birthday)	If Under 1 Year Months Days		r 24 Hrs. Min.	8. Date of Bir (Month, Da	th y Year)	9. Birth	place (State o	r Foreign
Direc	ctor		239-18-5234	X W Z L	98	Yrs.				Feb. 1	9,1908	Nor	th Caro	olina
and	20	}	Usual Residence of Decedent 10a, State 10b, County		10c. Cit	y, Town or Lo	cation						10d. Inside Cit	ty Limits
the Marylan 28a-f ehow	a Da	ö	MD Ann	e Arundel	A	nnapol	lis						1 ☐ Yes	XXNo
the N	and the second	ect	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	
illed within 72 hours after death with the Maryland Hygiene.	2	Funeral Director	705 Americana D	rive			214	₊ 03			_	SA	,	
Jeath Tre 2:		era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. 1	Was Decedent of If Yes, specify Cub	Hispanic Or	rigin? (Spe	ecify Yes or No	- 14. F	lace - Amer		
after dea or items	100	교	1 Never Married 2 Marrie	Armed Forces	No .					Rican, etc.)		Black, White		
ours a	Exa	by	3 ☐ Widowed 4 X Divorced	ed XXYes 2 ☐ If Yes, Give Year or Dates:	1942-	-46	1 ☐ Yes 2 🎇 No	Specify	' :		Spe	cify: W	hite	
72 hours	lica	Completed	15. Decedent' (Specify only highest	s Education		16a. Deced	dent's Usual Occu	pation during mos	st of worki	na	16b. Kind of	Business/I	ndustry	
ithin it	2	npl	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work done DO NOT use retire	ed)			_			
lygier hertl	4		47 Fatharda Norma (Greek Middle 1	4		Journ	nalist	10 14-15	anda Mana	(Cinnt Adiabata		nalis	m	
D D D D D D D D D D D D D D D D D D D	• V	Be	17. Father's Name (First, Middle, L Thomas B. Smit							First, Middle Snyder		iame)		
y Nould	Tangle	၉	19a, Informant's Name/Relationsh			10h Maille	- 4 11 (0	1				- C 7	· 0-4-1	
12 st hand 7 ten	trau		Barbara Howell				ng Address <i>(Str</i> ee Statesio				-			
1 and Healt	other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition	(Daughter)	20b. P	lace of Dispo	sition (Name of			Date	20c. Locatio			
ri og s	0 00		1 ☐ Burial 2 X Cremation				matory or other pla ematory	ice)	5-2-	2006	Baltim	-		
partition of the prairie of the permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If I tem 27 is marked other then	in in		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		rie			ess of Facil				orc,		
	eny l		13- 7.	Cyre-			Name and Addr Hardesty 12 Ridge	Fune	eral :	Home, H	A.	MD 21	401	
_			23a. Part1. Enter the disease, or	complications that cause	d the deat	h. Do not ent				_		1110 21	Approximate	9
Physic	ian		shock, or heart failure. List of Immediate Cause (Final	omy one cause on each	[n.	0,	Am 1	11-					Onset and D	
/Med			disease or condition resulting in death)	a. Due to (or as	a conseq	uence of):	1009	/Muc	<u> </u>					
Exami	iner		- 10 Page 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10				l							
	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Observe or injury											
cuted	ransi	Examiner	that initiated events	с										
ate be executed hysicien and	urial	E	resulting in death) Last	Due to (or as	a conseq	uence of):								
sate b	the b	dlcai		d										
entific Jing p	99 98	/Me	IF FEMALE:	23c. If yes, outcome	of orogno									
atten	ا م	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fete	I death 3	Ectopic pregnand Other (specify)	у				Date of delik Month		/ear
r.O. DOX, or or or or or or or or or or or or or	ched	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	it time or a	6alii 5	_ Other (specify) _							
thet led by	deta		Part II. Other significant conditio	ns contributing to death t	out not res	ulting in the u	nderlying cause g	ven in Part	I.	23e. Did t	obacco use c	ontribute to	the cause of d	eath?
uires n sigr	ed be	d by	- Laile	2 to 1to	rue					10	Yes 2 □ No	3 ☐ Pro	bably 4 Db	nknown
S × eq	shor	Completed	- Deon	A.10						24a. Was		b. Were aut	opsy findings a	available
The la	age	mo									rmed?	prior to death?	ompletion of ca 2 □ No	ause of
an: Tifica	tor, p	0	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes		TUTES	2 NO	
ysicl is ce	direc	To B	examiner? 1 ☐ Yes 20☐ No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatien	t 3 DOA O	har	_	me 5 ☐ Resi		Other (Spec	ity)	
Te 9 C	neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ury ay Year)	28b. Time of	f 28c. Inju	ry at	1	28d. Describe	now injury occ	urred		
eath.	the fu	catio	2 ☐ Accident investig	ation				Yes 2]No					
or At fler d	in by	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		iury - At ho tc. (Specif	ome, farm, str y)	eet, factory, office		1	28f. Location (City or To	Street and Nu vn, State)	mber or Rui	ral Route Numi	ber,
pital ours a	De li		29a. Certifier	Physician: To the best	of my kao	wladaa daatt	h accurred at the	ma data a	nd place of	and due to the			-1-1-1	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and	etely	Medicai	(Check only) 2 Medical E	xaminer: On the basis of	of examina	tion and/or in	vestigation, in my	opinion, de	ath occurr	ed at the time,	date and plac	e, and due	to the cause(s))
o thin	дшо	Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Date sig	ned (Month	Day, Year)	
~ > ~	-						10	57	02	28	05	1011	010	
			30 Name and address of person	who completed cause of	death (Iten	23a) (Type,	Print)	dita	Chris	a / `		~	VU	
			600 RIDG	RIU HV	25	uite	1 HO3	I FF	MMC	1169	SIM	10	214	01
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06-02913 Alan Smith

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Department of Fig. 1.		, ,	eg. No. 200	5 1577
Physicia Medical Exami		Decedent's Name (First, Middle,Last)		2. Date of Dea Month April 30, 2		3. Time of Death 0952 hrs
		4a. Facility Name (if not institution, give street and number) 4b. (City, Town, or Location of D		4c. County of Death	
			a Plata		Charles	
Funeral Director			f Under 1 Year If Under 24 Months Days Hours	Min.	rth(MM/DD/YYYY) 9 Birt Foreig 11, 1951 Cou	hplace (State or nWashington untry) D.C.
' any		10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
Varyland 28a-f show any <u>d at once.</u>	ē	Maryland Prince Georges Brandywine				1 X Yes 2 No
ith the Mary 23a or 28a notified at	uneral Director	7504 Earnshaw Dr.	20613		Og. Citizen of What Cour United Stat	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatit event, the Medical Examiner must be notified at once.	by F	1 Never Married 2 Married Armed Forces? If Yes, s 1 Yes 2 No 1 Yes, Sieve Year or Dates: 1 Yes	ecedent of Hispanic Origin? specify Cuban, Mexican, Pus $2 \overline{X} $ No specify:	erto Rican, etc.)	White, etc. Blace Specify:	ck
2 hour "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Jsual Occupation (Give kind of working life. DO NOT use	of work done retired)	16b. Kind of Business/Ir	ndustry
036 ithin 7 ne r than ledical	mple.		k Clerk		Private	
15-0 filed w Hygie d othe		17. Father's Name (First, Middle, Last)		ame (First, Middle, N	,	
2121 ald be a Mental marke	To Be	Charlie Smith 19a Informant's Name/Relationship (Type, Print) 19b Mailing Add	dress (Street and Number	rie Johnso		7.0
and 2 should be filed within 7 and 2 should be filed within 7 teath and Mental Hygiene tiem 27 is marked other than traumatic event, the Medical		Gloria Jean Roberson Smith/Wife 7504 Ea	arnshaw Dr. I	Brandywin	e, Md. 2061	_
nore, ages am mt of Heal nt: If item		20a Method of Disposition 20b Place of Disposition 20b Place of Disposition crematory or other p	(Name of cemetery,	Date	20c. Location - City or	Fown, State
Baltimore, permit. Pages I an Department of Hea Important: If iter		4 Donation 5 Other Specify: Resurrection		ay 6,2006		
Balt permit Depart Impor	-	21. Signature of Funeral Service Licensee 22. Name A Les 5538	and Address of Facility xander S. Por 8 Mariboro P	e Funera	L Homes, P.A.	20747
Physician	\dashv	23a. Part Enter the prisease, or populications that caused the death. Do not enter the mind failure. List only one cause on each line.				Approximate Interval
/Medical :xaminer	Ì	Immediate Cause (Final disease a. Thrombosis right coronary artery				Between Onset and Death
/		or condition resulting in death) Due to (or as a consequence of):				
	le	Sequentially list conditions, leading to immediate cause. Enter Underlying Cause				
	Examiner	(Disease or injury machinilated events resulting in death) Last Due to (or as a consequence of):				-
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760, Trate be extra physician the burial	/Medical	UNPENDED AMENDED IF FEMALE: 23c, if yes, outcome of pregnancy				
lox 68 eath certif	Physician/N	23b. Was decedent pregnant in the past 12 months?	eath 3 Ectopic pre	gnancy	23d. Date of delivery Month Da	ay Year
P.O. E es that the digned by the	by P	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		bacco use contribute to the	
ords, F	fed				2 No 3 Proba	
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed			autops perform	sy prior to co	opsy findings available mpletion of cause of
tal Recian: The certificat		25. Was case referred to medical	26.Place of Death (Che	1 Yes 2	No 1 ✓ Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Other:		Residence 6 Other:	
n of ding Ph		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)		28d. Describe h	ow injury occurred	
Sion Attender death rector: by the	cati	2 Accident Investigation 28e Place of Injury. At home, form, street, fee	1 Yes 2 No	200 1 10		
Divis ospital or At hours after d neral Direct y filled in by	Certification:	Suicide 6 Could not be determined (Specify)	story, office building, etc.	or Town, St	treet and Number or Rura ate)	I Route Number, City
Di To the Hospital within 24 hours a To the Funeral	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, is and manner stated.	it the time, date and place, a n my opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as starte and place, and due to the	d cause(s)
	Σ	29b. Signature and title of certifier	29c. License number		29d Date signed (Monti	n, Day, Year)
		20 Name and oddraw of passes when the	O.C.M.E.		May 1, 2006	
R/7/		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 212	201		
Sta		31. Date filed (Month, Day, Year) Registrar's Signature				
Registr		MAY 0 4 2006 Plane & April				
DHMH 17 Rev 1/20	U1	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Sims

3. Time of Death

10d. Inside City Limits

BLACK

1 Yes 2 No

20785

access

Year

Approximate Interval Between Onset and Death

10 days

10 years

Day

2X No

0928 AM

Day

Year

2006

Month

May

Physician /Medical
Examiner

1 - For State Registrar

Belinda

death with the Manyland

Baltimore, Maryland 21215-0036

permit. Pages Department of H Important: If its any Injury or of **Physician** /Medical Examiner

ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Box 68760. P.O. been signed by the should be detached Division of Vital Records. certificate the Hospital or Attending Physician: director this death. **Director**: ۾

4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Hospital Baltimore Johns Hopkins The 7. Age (In yrs. last birthday). 50 yrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F Director 257-88-0461 JUNE 11 1955 SOUTH CAROLINA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Pages 1 end 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If itsm 27 is marked other than "naturst", or itsma 23a or 28e-f show ury or other traumatic syent, the Madical Examinar must be notified at Director MD PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20715 15905 PINECROFT LANE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 yrs PROGRAM MANAGER GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BESSIE COWAN ROSS HARRISON ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15905 PINECROFT LANE BOWIE, MARYLAND SIMS/HUSBAND CHARLES 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GAINESVILLE, GEORGIA ALTA VISTA CEMETERY 5/6/2006 4 □ Donation 5 □ Qther (Specify) 21. Signature of Fundaral S 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Biventricular heart failure disease or condition resulting in death) myocardial infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Coronary artery

Due to (or as a consequence of): disease that initiated events resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 25 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after To the rivers and withouts and the Funeral Division Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatureland title of certifier may 1,2006 amp MD RES-000 卫人

State Registrar

DHMH 17 Rev 1/2001

North

wolfe Street

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600

2. Registrar's Signature

Camp,

MAY 0 4 2006

Melissa 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 21, per if Ed. 886 04/27/07dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician 2006 Рм 6:10 Ernestine L. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 17, 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Washington, DC 1 ☐ M 2 ☐ F 579-36-0237 76 Director Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County worle ! rel', or items 23a or 28a-f ehor Exemples must be notified at 1X Yes 2 No Lanham Maryland Prince George's Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 7935 Johnson Avenue USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ð 3 Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill ment of Health and Mental H ant: If item 27 le marked ott Beatrice Baylor Charles Berry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 445 Seahorse Run, Chesapeake, Virginia f Health item 27 l Lori Nichols/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If its eny injury or ot once. Burial 2 Cremation 3 Removal from State 5/5/2006 Washington National Suitland, Maryland 4 Donation 5 DOther (Specify) Ralph Williams Funeral Services 21. Signature of Funeral Service Licensee ▶ Ralph E. Williams (per DVR) 1813 Potomac Avenue, SE, Washington, DC 20003 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Complications of Chest Injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic cardiovascular disease, Bilat. Rulmonary Embolism, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unknown Sepsis, Acute congestive heart failure, hypertension, 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ▼□ No Hypothyroidism, acute hypothyroidism, acute respiratory failure. 1□ Yes 2√ No 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 √Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ After thi 28d. Describe how injury occurred Subject driver of a car that 28a, Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 3:48 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 No Feb. 7, 2006 investigation 2 XAccident
3 Suicide collided with pickup truck. 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State Martin Luther King Hwy. & Johnson Avenue, Glenarden, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicide Roadway within 24 hours a To the Funeral (29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) OCME April 27, 2007 MO Lonus-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Aronica-Pollak, M.D. 111 Penn Street, Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2 7 2007

			State of Marvia	and / Depa	artment of Health	and M	ental Hyd	iene			
		1 - State Registrar	,		rtificate of Deati			17 19	06 15780		
		Decedent's Name (First, Middle, Last)	-				2. Date of Dea Month	th	3. Time of Death		
Physici /Medio		Melvin Norma	an Te	ffeau			May 10	, 2006	7:21 p M		
Examin		4a. Fecility Name (If not institution, give stre			4b. City, Town, or Location	n of Death		4c. County of	of Death		
		Atlantic General F		en last hirthday	Berlin If Under 1 Year If Under	er 24 Hrs.	O Data of Birth		ester		
Funeral Director		5. Social Security Number 6. Sex	7. Age (in y	rs. last birthday) Yrs.	Months Days Hours	Min.	8. Date of Birth (Month, Day) Feb. 23	Year)	9. Birthplace (State or Foreign Country) Maryland		
		Usual Residence of Decedent	/4				reb. 23	, 1932	Maryland		
rylan	_	10a. State 10b. County	10c.	City, Town or Lo					10d. Inside City Limits		
8a-1	cto	Maryland Charles		Hughes					1 ☐ Yes 2 No		
with the	Funeral Director	10e. Street and Number	7.1		10f. Zip Code		1	0g. Citizen of Wi	•		
eeth v	erai	7042 Bluebird Hill 11. Marital Status 12.	Place Was Decedent Ever in	0115 13	20637	Origin? /Spe	of Voc or No	U S A	- American Indian,		
ritar d	E	1 Never Married 2 Married	Armed Forces?	10.0.	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	an, Puerto I	Rican, etc.)		, White, etc.		
ours a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 Yes 2 XNo Specif	fy:		Specify:	White		
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within 100.	m	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			Marer 1 am i	1 Chata Dalia		
Hygia Hygia ther		17. Father's Name (First, Middle, Last)		St	ate Trooper	ther's Name					
	To Be	Emmons L.	Teffeau			thari			Plum		
de de de	-	19a. Informant's Name/Relationship (Type,	, Print)	19b. Maili	ng Address (Street and Num.	ber or Rura	l Route Number	City or Town, S	State, Zip Code)		
C, Mal yld s 1 end 2 should f Health and Mer item 27 is marke other treumatic		Shirley B. Teffeau,				.1 Pla	ce, Hug	hesville	e, MD 20637		
P SE TO THE POST OF THE POST O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem			osition (Name of matory or other place)			20c. Location - C	City or Town, State		
t. Pag thmen tant:		4 ☐Donation 5 ☐ Other (Specify)	M		ans Cemetery						
permit. Pages 1 end 2 Department of Health a important: if item 27 is any injury or other tre		21. Signature of Funeral Service Licensee	Sats	B 3	2 Name and Address of Fac Pinstield-Ech 0195 Three No	otch R	uneral d., Cha	Home, Priotte F	A 11, MD 20622		
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/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	1		d				
					and a			cr. City or Town, State, Zip Code) ghesville, MD 20637 20c. Location - City or Town, State Cheltenham, Maryland Home, P.A. arriotte Hall, MD 20622 rest, Interval Between Onset and Death			
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			1 - For State Registrar	State of Maryl		artment of F ertificate of		d Mental Hy	giene Reg. No. 2	006	15781
	Physici /Medic		Decedent's Name (First, Middle, Last)	Eunice Agat		2. Date of De Month May	Day	Year)6	3. Time of Death 10:30 P M		
	Examir		4a. Facility Name (If not institution, give s	25		4b. City, Town, o				ounty of Death	
	Funeral		13590 Ryceville Ro		yrs. last birthday	Mechani If Under 1 Year	If Under 24 h	Irs. 8. Date of Bir	rth	harles	place (State or Foreign
	Director		216-40-8140	M 217 F	91 Yrs.	Months Days	Hours N	March 9.	1915	Mary	intry)
ī	pur *		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation					10d. Inside City Limits
	Maryla febo	Į.	Maryland Charles		lechanic						1 ☐ Yes 🏋 T No
	r 28e	Director	10e. Street and Number	1.	еспаптс	10f. Zip Code			10g. Citizer	n of What Cou	
	23a o	al D	13590 Ryceville Ro	oad		20659)		USA		
	er dee	Funeral		2. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.))- 14.	Race - Amer Black, White	
50	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2.□.No ff Yes, GiveXX Year or Dates:		1 ☐ Yes XX No	Specify:		Sp	oec <i>ify:</i> Whi	te
0500-c	172 hours after deeth with the Maryland "netural", or Items 23a or 28e-f ehow idical Exeminer must be notified at		15. Decedent's Educ	cation	16a. Dece	edent's Usual Occup	pation	wardsin a	16b. Kind	of Business/I	
7	c * @	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	1	b kind of work done DO NOT use retired	d)	working		-	
7	e filed within al Hygiene. I other than " vent, the Mai		9 17. Father's Name (First, Middle, Last)		H	omemaker	18 Mother's I	Name (First, Middle		wn Hom	e
yland	ild be flental }	To Be	James Ernest (Praves				Long	, Maidell 30	mattie)	
	2 should be and Mental is marked of raumatic ev	-	19a. Informant's Name/Relationship (Typ		19b. Mail	ing Address (Street		Rural Route Numb	er, City or To	own, State, Zi	ip Code)
, Ma	s 1 and 2 should be filed within f Heelth and Mental Hygiene. Item 27 is marked other then other traumatic event, the Memore traumatic event.		James A. Turner /				Road, Med	chanicsville	e, Mary	land 206	59
ore O	Pages 1 nent of He int: if Iter iry or oth		20a. Method of Disposition 1 ↑ Buriaf 2 □ Cremation 3 □ Re		 b. Pface of Disp cemetery, cre 	osition (Name of matory or other place	ое)	Date	20c. Locat	tion - City or T	own, State
altimor	it. Partimentant:		4 Donation 5 Other (Specify) 21. Signatute of Funeral Service License	71		's Cemetery				za, Mary	land
D D	permit. Pages Department of I Important: if Ite any Injury or or once.		Markenel Ka	Gardene.	N	attingley-G	ardiner I	Funeral Home town, Maryla	e, P.A.	50	
			23a. Part1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the c							Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition	ASC	VD						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):						-
	* * * * * * * * * * * * * * * * * * *	7	Sequentially list conditions, if any, leading to immediate								
	uted d ansit	Examiner	cause (Disease or injury that initiated events	Due to (or as a con	304001109 (1).						
'n	exection and rial-tra	Exa	resulting in death) Last	Due to (or as a con	sequence of):						
0 / o	licate be executed physicien and s the burial-transit	edlcal	€ d								
0	certific nding p		IF FEMALE:	3c. If yes, outcome of pre	nonancy						
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į.	by the	hysl	1 ☐ Yes 2X No 9 ☐ Unknown	9□ Unknown							
'n	law requires thet the death es been signed by the etter 2 should be deteched for u	ρ	Part II. Other significant conditions conf	tributing to death but not	resulting in the i	underlying cause give	en in Part I.		1		the cause of death?
cords,	requir	Completed					·	- 10		0 3□ Pro	bably 4 □Unknown
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g	Physiclen: The lav this certificete hes al director, pege 2	Be Co	25. Was case referred to medical				26 Place of F	1 ☐ Yes Death (Check only o	200 No	1 🗆 Yes	2 □ No
>	ysich nis cer direct	To B	examiner? 1 ☐ Yes 2 No	ospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth		A		Other (Speci	fy)
	ing Pl		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Work		28d. Describe I	now infury or	ccurred	
VISION	death death ctor: ,	Icat	2 Accident investigation 3 □ Suicide 6 □ Could not be	28e. Place of Injury - A	At home farm st		Yes 2 □ No	28f Location (Street and N	umber or Rus	al Route Number.
2	al or A efter I Dire d in b	Certification:	4 Homicide determined	building, etc. (Sp	ecify)	reat, ractory, onice		City or Tov		uniber of Fig.	ar noble wallber,
	To the Hospital or Attending Physician: within 24 hours elfer death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of my er: On the basis of exam and manner stated.	knowledge, dear nination and/or in	th occurred at the tin	ne, date and pla pinion, death oc	ace, and due to the courred at the time,	cause(s) and date and pla	d manner as s	stated. o the cause(s)
	o the	Med	29b. Signature and title of certifier	A TO THAINING STATEOU.	7	29c. License	e number		29d. Date si	igned (Month,	Day, Year)
	1		> //	Der.	a bo	- 200	050	6	51	15/0	6
	10 50		30. Name and address of person who cor								
8	Sta	to	Leon W. Berube, M.D. 31. Date filed (Month, Day, Year)	28170 Old Vill 32. Registrar's Si		Mechanicsv:	ille, Mar	yland 20659			
	Registr		MAY 9 2006		& Sugar	K.					

		-	For State		ryland / Depa		lealth and M	lental Hyg	giene ge. No. 2006	15782			
			Registrar 1. Decedent's Name (First, Middle, Last)			timodito or	20411	2. Date of Dea		3. Time of Death			
	Physici	an	Patricia		Throne	2		May 1	1. 2006 Yeer	745 am ^M			
	/Medic Examin		4a. Facility Name (If not institution, give s 7011 Ridge Road	treet and number)	IIIOIK	4b. City, Town, o	or Location of Death	ray 1	4c. County of Dea Maryla	th			
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign			
	Director		2//-18-99/2 Usual Residence of Decedent	M 223 F	85 Yrs.	Months Days	Hours Min.	Nov 15,	1920 0	ountry) NiO			
	a-f ehow	ctor	Maryland Frederic		10c. City, Town or Lo Freder				· •	10d. Inside City Limits 1 ☐ Yes 2 ☒ No			
	h with the 23a or 28	al Director	10e. Street and Number 7011 Ridge Road			10f. Zip Code	17 02	1	log. Citizen of What C	ountry?			
980	i within 72 hours after death with the Maryland liene. r then "naturel", or lieme 23a or 28a-1 ehow the Mudical Examiner must be mailfied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2XXVI If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	Hispanic Origin? (Spean, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)					
Baltimore, Maryland 21215-0036	within 72 horens. ene. then "nature he Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired gistered	during most of work d)	ing	16b. Kind of Business Health C				
72	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	3		510 00100	18. Mother's Name	e (First Middle.		- C			
yland	id be ental ked o	To Be	Ralph		Bennett		Sarah		Weaver				
, Mar	27 le		J. Arthur Throne		701	1 Ridge H	Road, Fred	derick,_		1702			
ore	o to to		20a. Method of Disposition 1	emoval from State	cemetery, crei	matory or other plai	ce)						
ţ													
Ba	permit. Depertr Importe eny inju		Kall-mon k	Bersowy	007061	06 East (Church Sti	reet. Fr	ederick. M	ne ID 21701			
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	he death. Do not ent al Vascul			or respiratory arr	rest;	Approximate Interval Between Onset and Death 20 years			
	/Medical Examiner	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hyper	tension consequence of):	T.T.				20 years			
8760, ¬	tate be executed by sicien and the burial-transit	dical Examin	that initiated events resulting in death) Last		consequence of):	11				15 years			
.O. Box 68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у	-300	23d. Date of de Month	olivery Day Year			
ds, P.	luires thet n signed b	ρ	Part II. Other significant conditions con	stributing to death but	not resulting in the u	nderlying cause gro	ven in Part I.		bacco use contribute t es 2. X No 3. ₽	o the cause of death?			
of Vital Records,		Completed						24a. Was a autop: perfor	sy prior to death?	utopsy findings available completion of cause of			
/ita	Physicien: Tribis certification all director, partition and the control of the co	Be (25. Was case referred to medical examiner?			100	26. Place of Deat	h (Check only or	ne)				
) jo	Physic this c	ဥ	1 Yes 2 XNo		t 2 ER/Outpatie		4 Nursing no		ence 6 Other (Spe	ecify)			
Division	tending leath. tor: Afte the fune	Certification:	1 XNatural 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day		M 1 □	rk?]Yes 2 □ No		ow injury occurred treet and Number or R	ural Route Number			
Ρ	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		4 Homicide determined	building, etc.	(Specify)		ma data and sissa	City or Tow	n, State)				
	To the Hoepital within 24 hours a To the Funerel is completely filled	Aedical	(Check only 2 Medical Examir one)		examination and/or in	vestigation, in my o	opinion, death occurr	red at the time, d	ause(s) and manner a late and place, and du	e to the cause(s)			
		Σ	29b. Signature and title of certifier	Pini	. M	D462			May 11, 20				
	2		30. Name and address of person who co Martha J. Pierce				et, Frede	rick, Ma	aryland 217	701			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 8 2006	33. Registra		de							

		•	1 - For State Registrar	State of	Marylar		artmen rtificat				fental H	ygien Reg. N	6 U L	16	5	183
	Discorded		1. Decedent's Name (First, Middle, Las.	1)							2. Date of D Month	Death Da	ay	rear	3. Time of	Death
	Physici /Medic		Ruth			nomas					Apri1	27	200	6	6:09	р м
)	Examin		4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location	of Death		4	c. County of	Death		
			Chesapeake Hospi					inth:	icum If Under	. 0.411-0					unde1	
	Funeral		5. Social Security Number 6. Se	x □ M 252F 7	Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	Hours	Min.	8. Date of B (Month, L Nov • 1	lirth Da <i>y, Year</i> O 10	36 1	Cour	lace (State o	ir Foreign
	Director		579-03-4648 Usual Residence of Decedent		89						Nov. 1	2,19	10 1	nar y	Iand	
	and w		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside C	ty Limits
	daryl f ehc	ō	MD Montgome:	rv	,	[akoma	Park								1 🗌 Yes	2 1 No
	289.	Director	10e. Street and Number			Lancina	10f. Zip	Code				10g. C	itizen of Wh	nat Cour	itry?	
	3s or	٥	7051 Carroll Ave	nue				209	912				USA			
	death ms 2:	Funeral	11. Marital Status	12. Was Deced		J.S. 13.	Was Dece	dent of H	ispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	No-	14. Race			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat most be inclifted at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Ford 1 Tyes If Yes, Give Year or Da	2 📉 No		it Yes, spe 1 ☐ Yes				Hican, etc.)		Specify:	White,	white	
Ş	ture ture	- Pa	15. Decedent's Ed			16a. Dece	dent's Usu	al Occupi	ation			16b.	Kind of Bus	iness/In	dustry	
15	n ne	Completed	(Specify only highest grad		dor E . \	(Give	kind of wo DO NOT u	rk done d se retired	during mos I)	st of work	ting .					
12	with liene.	E	Elementary/Secondary (0-12)	College (1-	401 5+)	Supe	rvis	or				D.	C. Go	vern	ment	
0	filed wit Hygien other th	Bec	17. Father's Name (First, Middle, Last)			1	,		18. Moth	er's Nam	e (First, Midd	le, Maide	n Sumame,)		
a	id be ental ked c	ToB	Robert Ballantyn	e					Ru	ıth W	illis					
چ	2 should be and Mental ie marked (-	19a. Informant's Name/Relationship (7			19b. Maili	ng Address	(Street	and Numb	er or Rur	al Route Num	ber, City	or Town, S	tate, Zip	Code)	
Š	and 2 lealth a m 27 is		Raymond D. Thoma	s, Jr.	(Son)	1912	Mor	ning	Mist	Dri	ve, Si	lver	Spri	ng,	MD 209	906
Baltimore, Maryland 21215-003	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		20a. Method of Disposition		20b.	Place of Dispo cemetery, cre	osition (Na	me of	e)		Date	20c. l	Location - C	ity or To	wn, State	
9	Pages nent of int: if it		1XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		itate	orge Wa	-			5-1-	2006	Ad	elphi	, MD		
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п	The state of	a ri	Immediate Cause (Final	one cause on ea	-11 Al	Res	mo	Da	4 1	La.	Persi				Onset and	
1	/Medical		disease or condition resulting in death)	a. Due to le	or & a conse	quence of):	7		1.7	fee	n n		2	4	4 0	7
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	*	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a conse	quence of):				- //	10		1		9	
	uted	E	cause. Enter Underlying Cause (Disease or injury that initiated events	0												
Ť	exec in an	Examiner	resulting in death) Last	Due to (or as a conse	quence of):										
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Box	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		∐Ectopic p	rognance	,				23d. Date		,	
	death e ette	ici B	in the past 12 months?	4☐Pregna	ant at time of		Other (s						Mont	h	Day	Year
o.	that the de ned by the e detached i	hys	9 Unknown	9□ Unkno	wn						-					
ري ص	The law requires that the ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions of	ontributing to de	ath but not re	sulting in the u	inderlying (cause giv	en in Part	I.	23e. Did	dtobacco	use contrib	oute to th	e cause of o	leath?
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ta		l au	25. Was case referred to medical			-			26. Plac	e of Deal	th (Check only			Cl	le x	nede
\equiv	w 70	To B	examiner?	Hospital: 1 🗆 Jr	npatient 2	ER/Outpatie	nt 3 D	OA Oth	er: 4□N	lursing H	ome 5□Re	sidence	ther	(Specif	1) Hos	ne
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Division of	ar de	tific	3 Suicide 6 Could not be determined	289. Place	of Injury - At h	home, farm, st	reet, factor	y, office			28f. Location City or 7	(Street a	and Number te)	r or Rura	l Route Num	iber,
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	To the by within 2. To the I complet	Σ	29b. Signature and title of certifier	Doc	1		29	c. Licens	e number	120		29d. D	ate signed	(Month,	uay, Year)	47
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			3. Name and address at erson who	completed caus	e of death (II	23a) (Type	Print)	/at 2	(A	Å	Man a	M	1 -2 411	1		
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	Regist	el .	₩ AY 0.3 200	h Alle	Add		AP									

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#4c.PenMEO PCC 5-4-06 cm Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 28 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Center Baltimos Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1⊠M 2□F Hours Min Director 214-19-1942 08 80 84 VA Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar must be outliked at Director 1 XYes 2 No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 10103 Juniper Drive 20721 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ No Completed by Specify 3 ☐ Widowed 4 ☐ Divorced Specify: "naturel". **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Secret Service Agent permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sheila P. Jones Frank A. Tolliver 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila P. Tolliver/Mother 10103 Juniper Drive, Bowie, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 05/05/06 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Strickland Funeral Services, P.A Eric 6500 Allentown Road, Camp Springs, MD 20748 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carol Halland Brain ~ 20 days Traumate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Tyes 2 X No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? wilus 24a. Was an autopsy performe certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA I Director: After this d in by the funeral d 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No investigation 0632 AM 2 Accident 8/06 Collision Motor Vehicle 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 2801 of Brown Station Road within 24 hours after To the Funerel Dire 4 - Homicide Many 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical npletely i 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) HOMES MD ddress of person who completed cause of death (Item 23a) (Type, Print) South Green Street HOMM AUNDA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 0 4 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. UUh 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician JAMES' WILLIAM WILSON May 10, 2006 1:02P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata Civista Medical Center Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) NOV • 13, 1933 PENNSYLVANIA 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1X M 2□ F 72 Yrs. 178-26-3466 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director XXYes 2 No MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 HIBISCUS COURT 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 [X] Yes, specify Cuban, Mexical
1 [X] Yes, Sive
1 Yes, Give
1953-1955 □ Yes 2 □ No Specify: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry 2 should be filed within 7: and Mental Hygiene. 18 marked other then "n Elementary/Secondary (0-12) Coltege (1-4or 5+) RAMP SERVICEMAN TWA AIRLINES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN ROY WILSON ETHEL MAUDE LOGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth an Important: If item 27 is many injury or other BARBARA WILSON-WIFE P.O. BOX 1786, LA PLATA, MARYLAND 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) M △ MARYLAND VETERANS CEM. 5-16-06 CHELTENHAM, MD 21. Signature of Fundal Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause of each line. PLATA, MARYLAND 20646 mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ROS **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Records. P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown DECUBITE 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient this 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-26064 05-10-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vidyasagar Anmangandla, MD 10583 Theodore Green Blvd. White Plains, Maryland20695

Date filed (Month, Day, Year)

2. Registrar's Siggature Pay, Year) 2006 State Registrar

		•	For State Registrar	State of Ma	aryland /	-	artment of		ind Me		giene- Reg, No.	2006	5	786
	W		1. Decedent's Name (First, Middle, La	st)					2	2. Date of De Month	ath Day	Year	3. Time	of Death
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	yland		10a. State 10b. County		10c. City, To	own or Lo	cation	_					10d. Inside (
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	or 28	Olre	10e. Street and Number				10f. Zip Code					en of What C	•	
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	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of f Yes, specify Cu	Hispanic Orig Iban, Mexican,	gin? (Spec , Puerto R	ity Yes or No ican, etc.))-	4. Race - Am Black, Whi		
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21215-0036	n 72 hours after death with the Marylan "natural", or Iteme 23e or 28e-f ehow edical Evandinar must be notified at		15. Decedent's E	ducation		Sa. Deced	dent's Usual Occ	upation			16b. Kin	d of Business	s/Industry	
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Box	eath certific attending p I for use as	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnar	2011			2	3d. Date of de	elivery	
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			30. Name and address of person who							, M.D.				
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		•	For State of Maryland / Dep	artment of Health and Mertificate of Death		iene 006	15787				
	* - *		Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death				
	Physicia		Jean Pauline Walls		May 1,	2006	20:25 P ^M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
	LABITUT	200	Southern Maryland Hospital	Clinton		Prince Ge	eorae's				
6.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign ntry)				
	Director		218-28-7341 1 M 2 X F 74 Yrs.	Worters Days Hours Will.	March 13	, 1932 Mary	/l'and				
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	coation			10d. Inside City Limits				
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	be filed within 72 hours after death with the Maryland at Hygiene. And Hygiene. And other then "natural", or iteme 23a or 28a-f ehow of other then "natural", or iteme 24a or 28a-f ehow event, Ite Medical Everalizat mind the notified at	ecto	Maryland Prince George's Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun								
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		erai	15211 Croom Road 11 Marital Status 12, Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri					
Maryland 21215-0036		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4XXVivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify:	Rican, etc.)	Black, White,					
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<u>Va</u>	2 should be and Mental ie marked o	ဥ	Anthony Przybysz	Pauline							
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ore			1 Burial 2 Cremation 3 Removal from State	amatory or other place)		20c. Location - City or T					
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Baltimore,	permit. Pag Department important: i eny injury o once.		NIV 0 1112 ()	22. Name and Address of Facility Iuntt Funeral Home		ld Washingt 5, Waldorf,					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death				
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	certif nding Ise a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	rery				
Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	clar	in the pact 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year				
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		by Pi	Part II. Other significant conditions contributing to death but not resulting in the	pacco use contribute lo	contribute to the cause of death?						
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Re	The lan	Ę	Des Add 'I'm sale and '	1-1.0004	autops	ned2 death?	mpletion of cause of				
ā	certifica rector,	S	25. Was case referred to medical	26. Place of Deat	1 Yes 2 No 1 Yes 2 No						
>		0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 DER/Outpatient	Other		ince 6 ☐Other (Speci	fy)				
of	g Phys er this eral di	n: T	27. Manny of Death 28a. Date of Injury 28b. Time	of 28c. Injury at Work?	28d. Describe ho	w injury occurred	-				
ion	uttending I death. ctor: After y the funer	atio	1 12 Natural 5 □ Pending (Month, Day rear) Intury 2 □ Accident investigation	M 1 Yes 2 No							
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Ö	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification:	Duraning, Oto. 10,00017)								
		Medical									
	ompl	Me	29b. Signature and title of certifier	29c. License number	2!		. Date signed (Month, Day, Year)				
	->-0		1 2 mg	D0027902	5.2.2006						
ı			30. Name and address of person who completed cause of death (Item 23a) (Typi	a, Print)							
1	NB 15		MULICAL OLIKNDRA 9131 6	reatorious Rd	CUNTO	N. ms.	20735				
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		State of Maryland / Department of Health and Mental Hygiene Certificate of Death									798		
			Registrar Certificate of Death Reg.							1. No. 4 U U O 0 / 0 U			
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)*	/Medic		Perlynn Wood		boom	4b. City, Town, or Location of Death				28 2006 0605 4c. County of Death			
	Examin	er	4a. Facility Name (If not institution						Jea(n	40			- 1
	S. 1. F. I		Anne Arunde	6. Sex	7. Age (In yrs. i	last hirthday)	Annapo		Hrs. 8. Date of B	irth		ne Arund	
	Funeral Director		572-54-5157	1 □ M 2X CXF	64		Months Days		Min. (Month, E Nov. 2	Day, Year,)	Country)	
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	/land		10a. State 10b. County		10c. City	y, Town or Lo	ocation		-			10d. Inside C	
	Mar.	to	MD Anne A	Arunde1	G	ambri]	l1s					1 🗆 Yes	XX No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What	Country?	
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	-me	d by Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U. forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	lo-	14. Race - A Black, W	merican Indian, hite, etc.	
	or It		1 Never Married 2 Marr	If Yes. G	2 MNo Sive		1 □ Yes 2 XX o	Specify:			Specify:	White	
	ture!		3 X Widowed 4 □ Divorced	Year or	Dates:	16a Dece	dent's Usual Occupa	ation		16h k	(ind of Busine	es/Industry	
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7	withi ene. than	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Secre				Depa	artment	of Def	ense
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	9 - 2 >	To Be	Milton Merle R	Lchardson				Ivy I	Pearlie B	urgo	on		
ary	should ind Men ind marke		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street a	and Number	or Rural Route Num	ber, City	or Town, State	a, Zip Code)	-
re,	and 2 saith a n 27 to		Susan Gilmour	(Daughter)	9915	Sudan Pla	ace, U	pper Marl	boro	, MD 20)772	0
	ter it		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	2 Domayal from	20b. P	lace of Dispo emetery, crei	osition (Name of matory or other place	e)	Date	20c. L	ocation - City	or Town, State	
Ĕ	Pages Thent of Hant: If Ite		4 Donation 5 Other (S				ematory		-2-2006	Ba	ltimore	e, MD	
Balt	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service	Licensee	11	2	Name and Address Hardesty	Funera	al Home,	P.A.	- 100 (01/01	
*	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or	complications that	caused the deat	h. Do not en	ter the mode of dyin	g, such as ca	nue, Anna irdiac or respiratory	arrest,	S, PID A	Approxima	te
			23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
			Sequentially list conditions										
		lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
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687	ficate g phys	edic											
Вох	leath certifica attending ph I for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregrant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 5 ☐ Other (specific pregnant at time of death 3 ☐ Other (specific p								23d. Date of delivery Month Day Year		
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=	Physician: The I this certificate har ral director, page								1 ☐ Yes	formed?	death 1 □ Y	es 2□ No	
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Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla	ce of Injury · At he Iding, etc. (Specif	ome, farm, st	reet, factory, office			(Street a		Rural Route Nur	nber,
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		edical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
		Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
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			30. Name and address of pers	o completed ca	use of death (Item	п 23а) (Тура	Print)	Λ	111	1		0	
	# # P		31. Date filed (Month, Day, Year	32	Registrar's Signa	ature	Jane	Trun	46/	100	((car)	Len !	CV
(a)	Sta Regist		MAY 0 3	409	the B	2	NE)						

State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OOAM Honth 1 **Physician** Victor Williams, Jr. 2006 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Dorchester General Hospital Cambridge If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 17, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 81 Maryland 217-16-9471 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Federalsburg Caroline Be Completed by Funeral Director MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. United States 21632 4417 Long Swamp Road Itema 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ty□Yes 2□No ffYes, Give Year or Dates: 143-46 t ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🗓 No White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Masonry Brick Layer 10 of Health and Mental Hygie litem 27 is marked other t r other traumatic evant, ib 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence V. Williams, Sr. Iva Phippin ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a :: If item 27 is r or other tra 4417 Long Swamp Rd., Federalsburg, MD 21632 Dorothy C. Williams/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Hillcrest Cem. 05/09/06 Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Michael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cirrhosis Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) the attending physician a thed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 22 No 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) cambridge Willi Dramble 100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 430

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 30, Day 2006 **Physician** 8:00p^M Anne Bernice Williams /Medical Facility Name (If not institution, give street and number)
Crescent City Nursing Home 4c. County of Death 4b. City, Town, or Location of Death Examiner Riverdale Prince Georges Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 ☐ ¥ Omaha, 92 May 9, 1913 Ne Director 507-07-3737 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Maryland Prince Georges College Park Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20740 7408 Sweetbriar Dr. United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withl Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, ILEM and once. Housewife Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Felton Peoples Dimple Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7408 Sweetbriar Dr. College Park, Md. James McCord / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑Removal from State May 10,2006 Garden of Memories Waterloo, Ia. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
2617 Pennsylvania Ave. S.E. Washington, D.C. 2002 21. Sign wure of Funeral Service Licensee Part 1. Exter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician fear-/Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of). the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed Yes 2 No Lenjion Typery 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Queens buy Rel Hyattsville KD 2078/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 22 ANNETTE WILLIAMS APRIL 2006 8:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 66 1939 Director 429-76-8499 10 ARKANSAS Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Exeminer must be notified at 1 Yes 2 □ No PRINCE GEORGE'S UPPER MARLBORO Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5605 SOUTH MARWOOD BLVD 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 YRS REGISTERED NURSE GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 le marked of J HARDER VANILLA HARLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 MANORFIELD COURT BOWIE, MARYLAND COURTNAY WILLIAMS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or once. RESURRECTION CEMETERY 4/29/2006 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending i 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) pec the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an has certificate 1 ☐ Yes 2**X** No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٤ 1 Yes 2 No 1 Alnpatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending Director: A d in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours efter To the Funeral Dirs 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

MAY 0 4 2006

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

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		•	For State Registrar	0.0.0	Certificate of Deat	h	Reg. No. 2006 15792
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1.	Physici /Medic		EARNEST	MILLI		APRI	L 20 2006 5 00 PM
	Examin Funeral Director	er	5. Social Security Number 6. Se 438-30-9238	Re Nursin		aton ler 24 Hrs. 8. Date of Birt	h, Year) 9. Birthplace (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Mas Vland Page 1	nce George,	y, Town or Location Witchol	Wille.	10d. Inside City Limits 1 Pres 2 No
	h with the 23a or 28a at be rott	al Director	100. Street and Number	inalake	DR. 10f. Zip Code	721	10g. Citizen of What Country? USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural," or items 23a or 28a-f ehow important: if item 27 is marked other than "natural," or items 23a or 28a-f ehow appring yor other traumatic event, it a Modical Exercitizat must be rediffed at once.	by Funeral	11. Marital Status 1 Never Married 2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	12. Was Decedent Ever in U Armed Forces? 1 12 es 2 No If Yes, Give Year or Dates: 191	TO Yes 2 THO Soec		14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	filed within 72 ho Hygiene. kther than "natur ent, ICe Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Sycopatary (0-12)	ucation de completed) Coltege (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)	nost of working	PRivate
Maryland 2	nould be filed if Mental Hygid narked other natic event, II	To Be C	17. Father's Name (First, Middle, Last) Nazie W	filliams	(6	ther's Name (First, Middle,	Maiden Sumame) L Habert City of Town State 7 to Code!
•	s 1 and 2 sho f Health and item 27 is ma other trauma		19a. Informant's Name/Relationship (7	1110MS	19b. Mailing Address (Street and Nun 1/028 Spring 10 Place of Disposition (Name of Demetery, crematory or other place)	Date	20c. Location - City or Town, State
Baltimore	permit. Pages Department of Important: If it any injury or o once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Pervice Licen	Hemoval from State	CIRYLAND VETERANS 22. Name and Address of Fa	5-01-2006 cility 53	Cheltenham, MD
ä	Depar Important in any ir) Cwa S.	Willel	Pope Funeral1	Homes, FOR	estville, MD. 20747
j.	Physician /Medical		23a. Part1. Enter the disease, o comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. INFECTE	th. Do not enter the mode of dying, such DECUBI	as cardiac offespiratory ar	Approximate Interval Between Onset and Death
3760,	Examiner	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect c. d	quence of):		
.O. Box 68	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Ω.	quires that an signed by uld be deta		Part II. Other significant conditions of		sulting in the underlying cause given in Pa		obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Durknown
II Reco	The lar	Completed	STROK	E			
Vita	Physician: The this certificete ral director, pag	Be C	25. Was case referred to medical examiner?	Hospital:	Othor	ace of Death (Check only o	
o	iding Physith. The After this of tuneral directions	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at		dence 6 □Other (Specify) now injury occurred
Division of Vital Records,	or Attending after death. Director: After in by the fune	edical Certification:	1 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		Injury Work? M 1 □ Yes 2 lome, farm, street, factory, office fy)		Street and Number or Rural Route Number, wn, State)
ب	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death occurred at the time, date ation and/or investigation, in my opinion, o	and place, and due to the death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier		29c. License numbe	er	29d. Date signed (Month, Day, Year)
	4,,		2hruer	~ you	mi 1) 00 3	8521	HPRIL 21 2006
	Bo 1/c		30. Name and address of person who SHVAL COSIV	completed cause of death (Item 90 Gb 32. Registrar's Sign.	olary Avrule h	HEATON, MD &)DGDJ
A. T	Sta Regist	ate rar	MAY 0 4 2006	Ban JA A	nets!		

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of Maryl		artment rtificate			nd M		giene Reg. No.	006	15793
7	Physicia		1. Decedent's Name (First, Middle, Las							2. Date of Dea Month May		Yeer	3. Time of Death
	/Medic	al	Margaret Eleanor			45 Ch. T		I continu	4 Dooth	May J		OU6 County of Death	5:05A M
)	Examin	er	4a. Fecility Name (If not institution, give St. Mary's Nursi					Location o ardto				. Mary	S
- Con	Funeral	1	Social Security Number 6. S	7. Age (In	yrs. last birthday,) If Under 1	Year	If Under 2	24 Hrs.	8. Date of Birt (Month, Da		9. Birth	place (State or Foreign
	Director		213-38-4189	□м 2🛛 F	93 Yrs.	Months	Days	Hours	Min.	Aug 23,	1912	Mary	
- 40-	pu .		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation							10d. Inside City Limits
	Aaryla I sho	ō											1 Yes 2 No
	the N	Funeral Director	Maryland St. Mai 10e. Street and Number	y s	CIIa	ptico 10f. Zip (Code				10g. Citiz	en of What Cou	ntry?
	h with	a D	38355 Chaptico Ro	ad, P.O. Box	x 31		20	621				USA	
	deat mms a	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decede	ent of Hi	spanic Orig	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	- 1	 Race - Ameri Black, White, 	
36	or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🐴 No If Yes, Give		1 ☐ Yes 2		Specify:				Specify: Blad	ck
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f show the Madical Exeminar must be notified at	ed b	15. Decedent's Ed	Year or Dates:	16a. Dece	edent's Usual	Occupa	ation			16b. Kin	d of Business/In	ndustry
15	nin 72	Completed	(Specify only highest gra Elementary/Secondary (0·12)	de completed) College (1-4or 5+)	(Give	e kind of work DO NOT use	k done d e retired	during most)	of worki	ng			
212	giene grene er the	E S	8	- Concyc (Hou	sekeep	ing					pital	
nd	be filed tat Hygid d other event,	Be	17. Father's Name (First, Middle, Last) William Baker							(First, Middle, Owman	Maiden S	Sumame)	
yla	d Men marke	P _C	19a. Informant's Name/Relationship (7	Supa Print)	19h Mail	ing Address	(Street s				ar City or	Town, State, Zij	n Code)
Mai	d 2 st th and th sist traun		Elanor Cecelia Fenwic							MD 206		, own, blace, 2,	3 3 3 3 3 3
ď.	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, the Madical Exeminar must be notified at		20a. Method of Disposition	20	b. Place of Disp	osition (Nam	e of			ate		ation - City or T	own, State
E	Page nent o nt: if iry or		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cemetery cre St. Jos Catholi	eph's c Cemet	ery	N	1ay 16	5, 2006	Morg	anza, M	aryland
Baltimore,	permit. Pages I Department of H Important: if ite eny injury or ot once.		21. Signature of Funeral Service Licen	see H	.0		ngley	y - Gardi	iner I	Funeral H			
			23a. Part1. Enter the disease, or com	olications that caused the	death, oo not er					town, MD or respiratory ar			Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	2100	200 M	5.	6	-0	Come	- //	? CL	Onset and Death
8760,	Medical Examiner physicien and the parial-transit	dical Examiner	Socrectially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord) Due to (or as a cord) Due to (or as a cord) d.	nsequence of):								
.O. Box 68	The law requires that the death certificate also been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pre					2	3d. Date of deliv Month	rery Day Year
rds, P	w requires that been signed b should be dete	b	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying ca	ause give	en in Part I.			obacco us Yes 2		the cause of death? bably 4 Únknown
I Records,	aician: The law re certilicate hes bee irector, page 2 sho	Completed			_					24a. Was autor perfo 1 Yes		24b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of
Vital	Phyaician: this certific ral director,	Be (25. Was case referred to medical examiner?	Manakali			0.5			n (Check only o			
of	this ald	L.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		A Oth	4 LYNU		me 5 Resident		Other (Speci	(fy)
uo	ting After fune	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Ye			Wor	k?" Yes 2 □	1	200. Describe	now injury	00001160	
Division	for Attending after death. Director; After in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined	e One Disease of Injury	At home, farm, s pecify)	street, factory,	, office			28f. Location (City or To			al Route Number,
0.	To the Hospital or Attenc within 24 hours after death To the Funeral Director; completely filled in by the	edical C		nysician: To the best of my niner: On the basis of exa and manner stated.									
P	omple	Med	29b. Signature and title of certifier	/		29c.	Licens	e number				signed (Month,	
	F>F0		> 111	my to	W		1)	428	5		5	-12-6	06.
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	e, Print)							
		253	William D. Boyd, II		t. Lookout	t Road,	Leon	ardtow	n, MD	20650			
é	St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 2 2	32. Registrar's		Sand o							

DHMH 17 Rev 1/2001

06-03045

Please Type or Print in Black Indelible Ink

	R	State of Maryland / Department of - For State Certificate of		Reg	1 No. 20	06 57
Physician/ al Examine	-	Decedent's Name (First, Middle,Last) Louise Lucine Yeatman		2. Date of Death Month May 3, 200	Day Year	3. Time of Death 1825 hrs
ui Examino			4b. City, Town, or Location of Death		4c. County of Deat	h
	į	Prince George's Hospital Center	Cheverly		Prince Georg	
Funeral	Ī	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Mir	1.	(MM/DD/YYYY) 9. 8i Forei	gn
Director		213-40-8400 1 M 2X F 90 Yrs.		10/06/	1915 C	ountry) Maryland
á u		Usual Residence of Decedent 10c. City, Town or Locati 10a. State 10b. County 10c. City, Town or Locati	ion			10d. Inside City Limits
Aaryland 28a-f show any latonce.	_	Maryland St. Mary's Leonardtow	√n			1 X Yes 2 No
the Maryland tor 28a-f sh iffed at once	ᇙᅡ	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cou	intry?
with the Maryland ns 23a or 28a-f sho be notified at once.		22680 Cedar Lane Ct. Apt.1305	20650	1	United Sta	tes
be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Rac Compilered by Filmeral Director	Jera L	1 Never Married 2 Married Armed Forces? If You	s Decedent of Hispanic Origin? (See, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	rican Indian, Black,
r mus	니	1 Yes 2X No	Yes 2 X No specify:		Specify Whi	te
urs aft ttural" amine		15. Decedent's Education (Specify only highest grade completed) 16a. Deceden	t's Usual Occupation (Give kind of	work done	16b. Kind of 8usiness	
permit. Pages I and 2 should be filed within 72 hou Department of Health and Metalle Hygiene. Department of Health and Metalle Hygiene. Important: If item 27 is marked other than "natinjury or other traumatic event, the Medical Examingury or other traumatic and Commission To Be Commission.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use ret	rired)		
within jene.	ᇍ		Keeper	e (First, Middle, Ma	Retail	
he filed at the street of the		17. Father's Name (First, Middle, Last) Herman H. Bosse		ne M. Nat	•	
Menti mark c ever			g Address (Street and Number or			e, Zıp Code)
d 2 sho) Chestnut Oak A			
s l and of Heal If iten		20a. Method of Disposition 20b. Place of Dispos X Burial 2 Cremation 3 Removal from State	sition (Name of cemetery, her place)	Date	20c. Location - City or	r Town, State
Page ment c tant: or oth	1	4 Donation 5 Other Specify: Charles Me		9/2006	Leonardto	
Depart m por njury	- 1		Name and Address of Facility Br			
ysician	+	Ky1e S. Simons M01206 22 23a Part I. Enter the disease, or complications that caused the death. Do not enter the	2955 Hollywood R he mode of dying, such as cardiac	d. Leona: or respiratory arres	rdtown Mar	yland 20650 Approximate Interval
Medical	ı	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				8 etween Onset and Death
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ath certificate be executed attending physician and or use as the burial - transit	Physician/iviedical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	~
ing ph	إلم	23b. Was decedent pregnant in the 1 Live birth 2 Fe	etal death 3 Ectopic pregn	ancy	1	Day Year
eath ce s attenc for use	Sici	past 12 months? 4 □ Pregnant at time of death 5 □ Ot 9 □ Unknown	her (Specify)			
by the ached f	좕	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
signed by be detach	핡			1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
v requir	Completed	7		24a. Was ar		utopsy findings available completion of cause of
The law cate has page 2 s	틹			perform 1 Y Yes 2	ned? death?	
certifica ector, pa	ğ B	25. Was case referred to medical	26.Place of Death (Check			
	∞	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other Nursi	- team	esidence 6 Othe	er:
hysicia this ce I direc	<u>,</u> 0	27. Manner of Death 28a, Date of Injury 28b, Time of I			ow injury occurred uto auto collision	
ing Physicis After this ce funeral direc	⊢⊦	1 Natural - FOLIND		_		
Attending Physicis death ctor: After this ce yy the funeral direc	⊢⊦	1 Natural 5 Pending Investigation May 2, 2006 1125 hrs	1 Yes 2 V No	205 1 (2)		
al or Attending Physici. s after death id Director: After this of ed in by the funeral direc	⊢⊦	2 Accident Investigation May 2, 2006 1125 hrs 3 Suicide 6 Could not be determined (Specific) Maior Page (Highway)	et, factory, office building, etc.	or Town, Sta	ate)	ural Route Number, City
toppical or Attending Physicis 4 hours after death uneral Director: After this ce by filled in by the funeral direc	Certification: T	2 Accident 3 Suicide 4 Homicide 29a. Certifier	et, factory, office building, etc.	Rt. 5 & Rt. 24	13, Leonardtown	ural Route Number, City
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			1 - For State Registrar	State of	of Maryla	nd / Depa	artment rtificate			ind Me		giene Reg. Né	006	1579	5
	5 1 % K		1. Decedent's Name (First, Midd	le, Last)						2	. Date of Dea Month	ath Day	Year	3. Time of Death	
4.	Physici /Medio	al		К.	Ashu	rkova				1			006	8:00a	М
	Examin		4a. Facility Name (If not institution		ımber)		4b. City, To	own, or L	ocation of	f Death		4c. 0	County of Dea	ath	
1			14 Mallory						ersl			Mc	ntgon		
	Funeral		5. Social Security Number 214-73-0247	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yr: 83	s. last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min. 8	. Date of Birt (Month, Da	v. Year)	_ 0	rthplace (State or Forei ountry)	gn
25	Director		Usual Residence of Decedent		03	TIS.					3/09/	192	3 R	ussia	
	and		10a. State 10b. County	,	10c. C	City, Town or Lo	cation							10d. Inside City Limit	ts
	f sho	ō	MD Mont	gomery		Gaith	ersbu	urg						1 ☐ Yes 2 X N	10
	158e	rec	10e. Street and Number				10f. Zip C	Code				10g. Citiz	en of What C	ountry?	
	3a or	۵	14 Mallory	Court			2	2087	9				USA		
	within 72 hours after death with the Maryland ene. than *natural', or itama 23a or 28e-f show he Madigal Examinar must be codified at	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in	U.S. 13.	Was Decede	nt of His	panic Orig	in? (Speci	fy Yes or No- can, etc.)		4. Race - Am	erican Indian,	
ထ	or its	Ē	1 Never Married 2 Ma	ried 1 ☐ Yes	2X No					, Puerto Hi	can, etc.)		Black, Whi		
<u></u>	ral", c	l by	3 ₩idowed 4 Divorce	If Yes, G Year or I	ove Dates:		1 ☐ Yes 2	IXI NO	Specify:				Specify:	White	
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<u>\Z</u>	Mental Marked o	၉											tsova		
Maryland	2 sh and is r		19a. Informant's Name/Relation			19b. Mailir	ng Address ((Street ar	nd Numbei	r or Hural F	Route Numbe	r, City or	Town, State,	Zip Code)	
	l and lealth im 27 her t		Yelena Safro	nova/Dau		14 Place of Dispo	Mallo	ry	Cour	t G	aithe	rsb	urg.M	d 20879 Town, State	
0	Pages 1 nent of H int: if its iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	State	cemetery, crei	natory or oth	her place,	- 1						
Baltimore,	tant:		4 □ Donation 5 □ Other (Rock C								on, D.C.	_
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show amportant in july or other traumatic avent, the Madical Examinar minal by a chillied at 2008.		21. Signaturi Funeral Service	thele.	*	9.	241 C	OLu	mbia	. blv	d.Sil	ver	SERVI Spri	CE, P.A.	0
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that t only one cause on	caused the de each line.	ath. Do not ent	er the mode	of dying,	such as	cardiac or r	espiratory ar	rest,	_	Approximate Interval Between	
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Ő	e exe		resulting in death) Last	Due to	(or as a conse	equence of):									
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	the a	sic	1 ☐ Yes 2 ██No 9 ☐ Unknown	4∐Preg 9☐Unkr	inant at time of nown	death 5	Other (spec	cify)		=				,	
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of Vital Records,	Attending Physician: The r death. sctor: After this certificate ha by the funeral director, page	Be	25. Was case referred to medic examiner?	Hospital:						of Death (Check only o	ne)			
of	Physithis dall dir	ဥ	1 ☐ Yes 2 ☑ No	1		ER/Outpatier			4 🔲 1901				□Other (Spe	ecify)	
n N	ding la	Certification:	27. Manner of Death 1 Natural 5 Pend	ing.	nth, Day Year)	28b. Time o Injury		Work?			d. Describe h	iow injury	occurred		
Sic	ttend death tor: the t	cat	2 Accident invest 3 Suicide 6 Could	not be	a of Asiasa AA	h 44	М		es 2 N		f Lanation /	20	(
Division	i Si te	rtif		nined 288. Plac	ding, etc. (Spe	home, farm, str cify)	eet, factory,	office		28	City or Tow		Number or H	lural Route Number,	
נ	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 TCertify	ng Dhysisia - T- '	a hast of the	aguila di a di di		A 4 b		d =1= : -	441.				
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	To the Hospital within 24 hours a To the Funeral Completely filled	Med	29b. Signature and title of certifi		nner stated.		29c	License	number			29d. Date	signed (Mon	th, Day, Year)	
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	2		30. Name and address of person					51. · ·					_		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Rebecca Alexander 12:30 p M May 11, 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2**X** F Nov 23, 1947 Maryland 218-48-1381 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County ahow r than "natural", or items 23a or 28a-f aho the Medicul Evantrar must be notified at 1 Nes 2 No **Baltimore** N/A Maryland Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number U.S.A. 21229 821 Stamford Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examina 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify. Black Baltimore, Maryland 21215-0036 ģ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Baltimore City School System Elementary/Secondary (0-12) Teacher's Aide 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mamie Carter Raymond Allen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 821 Stamford Road Baltimore, Maryland 21229 Daniel Allen 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/19/06 Lansdowne, Maryland permit. Page Department Important: If any injury of 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 22. Name and Address of Facility 21. Signatore of Funeral Service Lig Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAG Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending wheelving and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autons 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ≥SER/Outpatient 3□ DOA Certification: To 1 Tes 28c. Injury at Work? 28d. Describe how injury occurred After the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death Natural 5 Pending Natural 2 Accident 2 🗆 No 1 ☐ Yes investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date sign ed (Month, Day, Year) 29b. Signature and title of certifier 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUENUE E16141 PARV 32/Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Christiana Akuorkor Annan-Ackom Month 09/2006 Year **Physician** CHRISTIANA AKUOKOR ANNAN-ACKOM 1900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY **BETHESDA** SUBURBAN HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9/30/19/79. Birthplace (State or Foreign Months Days Hours Min. | 8. Date of Birth 9/30/19/79. Birthplace (State or Foreign Country) | GHANA | GHANA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 345-84-1278 58 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23e or 28a-f show the Medical Examiner must be notified at PRINCE GEORGE'S UPPER MARLBORO MD 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12810 MARLTON CENTER DRIVE 20772 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE NURSE 12TH permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: If item 27 is marked other tt
eny Injury or other traumatic event, IIIA
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 EMME MENSAH ROBERT ANNAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOREEN ACKOM-OWUSU/DAUGHTER 12810 MARLTON CENTER DR. UPPER MARLBORO, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State AWUDOME CEMETERY JUNE 17, 2006 ACCRA, GHANA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 21. Signature of Funeral Service License 4308 SUITLAND RD. SUITLAND, MD 20746 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) BREAST CANCER METASTATIC Physician 54RS. /Medical **Examiner** Cause, thatly not conuntous, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icete has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete has 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital c within 24 hours of To the Funeral D completely filled in t X Contifying Physician: To the best of my knowledge, Jeath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certfler Medical (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Nules Pryom D-23308 MAY 10,2006 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) 6420 ROCKLEDGE DR. #4100 BETMESOR, MO 20817 VICTORM. PRILEO, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

MAY 1 9 2006

5/09 10 W

		-	State of Maryland / Depart State of Maryland / D	rtment of Health and M rificate of Death		giene 200	6 15798
	g .		1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Yea	3. Time of Death
	Physicia /Medic		Mary Ellen Armstrong		May 17	2006	1:10 P ^M
	Examin			4b. City, Town, or Location of Death	1	4c. County of De	
		W:	Riverview Care Center	Essex If Under 1 Year If Under 24 Hrs.	To Date of Bigs	Baltim	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day 12-14	y, Year)	Birthplace (State or Foreign Country)
	Director	. }	Usual Residence of Decedent		12-14	- 29	MD
yland	MOK =		10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
Mar	a-f s	ctor	MD Baltimore Dundalk				1 Tes Anno
ith th	or 28	Oire	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What	Country?
ath w	23a	Funeral Director	101 Center Place, Apt. 214	21222	7.14	USA	- in the disc
er de	Items	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Ves 2 ☑ No	as Decedent of Hispanic Origin? (Speed, specify Cuban, Mexican, Puerlo	pecify Yes of No- o Rican, etc.)	Black, W	merican Indian, hite, etc.
rs aft	P. 1	by F	If Yes, Give 3 Widowed 4 Divorced Year or Dates:	Yes 2 No Specify:		Specify:	White
2 hou	atura	ted		ent's Usual Occupation	trin a	16b. Kind of Busine	ss/Industry
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N B	/gien ier th t, ibe	Completed		Homemaker		Own H	ome
	d off	Be	17. Father's Name (First, Middle, Last)			Maiden Sumame)	
y a	Men narke	٩	Thomas Martin, III			nown Mar	
Mal d2st	if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at		Table 901	Address (Street and Number or Ru			545.0904.0
ָם מַ	Healt em 2 ther		Cindy Alwine - Daughter 1774 20a. Method of Disposition 20b. Place of Dispos	Stokesley Roa	Date Dung	20c. Location - City	212 <u>22</u> or Town, State
ages	t: Kit		1 Rurial 2 M Cramation 3 Removal from State cemetery, crem.	atory or other place) Crematory 5-1	8-06	Baltimo	ro MD
altiffor	Department of Heal simportant: If item 2 any injury or other once.			Non- and Address of Capitle			
i e	Deparimbol any ir		Bethelet 21	Br 134 Willow Spr	adley-A	Ashton F	uneral Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
Ph	nysician		Immediate Cause (Final disease or condition	d Currhos	is of	Luce	Onset and Death
1	Medical		resulting in death) Due to (or as a consequence of):				
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pe	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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ath cert	endin use	N/CI	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ [8]	Ectopic pregnancy		23d. Date of d	
, 8	been signed by the attending pl should be detached for use as t	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
ords, P.O	d by the	Phy	9 Li Unknown	ded in the control of	. 22a Didta	ha and use contribute	to the equal of death?
is th	signed be d	by	Part II. Other significant conditions contributing to death but not resulting in the unit	William Harri.			to the cause of death? Probably 4 Unknown
ecords law requires	een s	eted	2000 000	f por vaj lo con			
§ ¢	has b	Completed	COPP, DIVI		24a. Was a autop: perfor	sy prior t	autopsy findings available o completion of cause of
1 The Tr	icate r, pag				1□ Yes	2 → N6 1 □ Y	
OT VITAL Physician: T	s certificate has t lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		th (Check only or	ne) ence 6 □Other(S	
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ION Puding	ath. r: Afte e fund	ation	1 12√Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No			
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ב פֿ	rs afte al Dir ed in	Certification:	building, our (openly)				
lospi	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ical	29a. Certifier (Check only (Ch				
the	the I	Medic	one) and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	inth Day Year)
J.	To		Alter M. D	D-3879	54	05-17	- 2006
	1	1	30. Name and address of person who completed cause ol death (Item 23a) (Type, F	Print) -	2	_	
1			MALIKA WASERM. 709	29c. License number D-3875 Print) EAST ERN	ISLUD.	MD-	21221
**	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A.F. a.			
	Registi	rar	MAY 1 9 2006 July 15 figures	GL.			

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State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Year Month **Physician** Inez Brown 2006 10:30P M May 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Crofton Crofton Convalescent Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days 1 M 200 84 Yrs 216-12-4656 Oct 5 1921 D.C. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Nedical Examinat must be notified at 1 Yes 2XX Odenton Maryland Anne Arundel Direct 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 1254 Collins Ave 21113 USA death v Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Black Specify: by 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Domestic Private Family O 7th permit. Pages 1 and 2 should be filed Department of Health and Mental Hygic Importent: If item 27 is marked other any injury or other traumatic event, It 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Thornton Jackson Susie Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14206 Old Stage Rd. Bowie, Md. 20720 Howard Turner(Son In Law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State John's Church 5-19-06 Odenton, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee eese MOO 483 821 West St. Annapolis, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Insek Physician 0515 /Medical Due to (or as a col sequence of): Examiner hete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine use as the burial-transit certificate be executed enebrove Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnap 3 Ectopic pregnancy Day in the past 12 mont jo 4☐ Pregnant at time of death 5 Other (specify) this certificate has been signed by the all director, page 2 should be detached in 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certification or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification; To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the funs. 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) person who apmpleted cause of death (Item 23a) (Type, Print) 30. Name and address of 1438) tense H Duda 32 Registrar's Signature 31. Date filed (Month. Day, Year) State

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State of Maryland / Department of Health and Mental Hygiene 🙎 🛭 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Prown /Medical 4a. Facility Name (If not institution, give street and number)
3536 White Chap 4c. County of Death Examiner more Balti Kd If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min 5. Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 F -22-0299 Mary land Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "netural", or itams 23s or 28e-f ehow the Medical Examiner must be notified at Md. 1XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? S.A 21215 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) Riveter 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: if item 27 is marked other the eny injury or other treumatic event. III. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Majden Sumame 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stevens (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph L. K 2222 W. No Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine siclan and burial-transit The law requires that the death certificate be executed attending physiclan Physician/Medicai the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. cate hes been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 3 ☐ Probably 4 ☐ Unknown 1 | Yes 2 1 16 Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□No 1 ☐ Yes 2/4/0 1 Tyes of Vital director, 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Yes 2 ☑ No P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Alter this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Alter 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Megreal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and the of certifie Name and address of person completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32 Registrar's Signature

06-03182 Delia Britt Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death Year **Medical Examiner** Delia E. Britt 0934 hrs May 11, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Clinton 1819- Southern Maryland Hospital Center Prince George's 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9 Birthplace (State or 220-80-0453 Months Days Hours Min Director 11/11/1954 Country) 1 M XX F Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. VA Portsmouth Portsmouth 1 X Yes 2 No nours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 161 Wilson Street 23701 Funeral 11 Marital Status 2. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XXvever Married 2 Married White, etc. 2 XXNo Yes f Yes, Give Year 3 Widowed Divorced 1 Yes 2 xxNo specify: Specify Black ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than 'atic event, the Medical 12 Baltimore, MD 21215-0036 Disabled N/A permit Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Rufus Britt Beatrice Powell æ 19a. Informant's Name/Relationship (Type, Print) ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Al Rufus Britt /Brother 1124 Horne Avenue, Portsmoouth VA 23701 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Linc. Cemetery Unk. Portsmouth, VA Donation 5 Other Specify. 21. Signature of Funeral Service Licensee
(per DVR)

Victor Doda

22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc
1501 E. Fort Ave. Baltimore MD 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21. Signature of Funeral Service Licenses **Physician** Approximate Interval failure List only one cause on each line Between Onset and /Medical Asphyxia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Food Bolus in airway Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical physician a X UNPENDED item#21,perFH,23a-b,27,28a-f,perME,G8556,7/12/06 TT AMENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown Hinknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by þ Yes 2 ✔ No 3 Probably 4 Completed certificate has been ector, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? page ✓ Yes ✓ Yes 2 No the Hospital or Attending Physician: ' 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ 2 FR/Outpatient 3 DOA Nursing Home 5 Inpatient this Residence 6 1 🗸 Yes ٩ 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Certification: subject choked on crackers during 1 Natural 1 Yes 2 χ No 5 Pending within 24 hours after death Fo the Funeral Director: 5/11/2006 9:00 am 2 X Accident dialvsis Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 19401 Hospital Drive 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be determined Dialysis Center (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical one) acal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signatu e and 29c License number 29d Date signed (Month, Day, Year) O.C.M.E May 12, 2006 who completed cause death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Day, Year) 32. Rogistrar's Signature 31. Date filed (Mont State Registrar

			For State Registrar		1)	Maryland	-	artment rtificate			and M	lental Hy	Reg. No.	006	proposed of	802
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21215-0036	d within 72 hours after death with the Maryland Jiene. r then "natural", or items 23a or 28a-f ehow the Madical Examinar must be collised at	ed	15. De	cedent's Ed	ucation	1,57	16a. Dece	dent's Usua	I Occupa	ation			16b. Kind	of Business	Industry	
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ē	es 1 and of Heelth I item 27 r other t		20a. Method of Disposition	1		20b. Pl	ace of Disp	osition (Nan	ne of			Date		tion - City or	Town, State	
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121			23a. Part1. Enter the dise	ase, or comp	plications that car	used the death	. Do not en							.,	Approxima	
			shock, or heart failur fmmediate Cause (Finaf	e. List only	one cause on ea	ch fine.									Interval Be Onset and	
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87	The law requires that the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical		•	d. Acute	Kespii	acory	rall	ure							
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	To t To t	Σ	29b. Signature and title of	certifier	- 12 A			29	c. Licens	e number			29d. Date s	signed (Mon.	th, Day, Year)	
	/		Vin	1 /20	ZN 1/1				DL	111	62		May 1	, 200	6	
	in Y		30. Name and address of	person who	completed cause	of death (ftem	23a) (Type	Print)								
	18		Vinu Ganti	, M.D.	. 1	9129 Do	octor	Dr.,	Germ	anto	vn, l	4D 20874	+			
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and a	Regist	rar	MAY 1	9 2006	Bondo	J. K.	Acres .	The state of the s								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician JOHN J. Burke 2006 11:25AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Fox Chase Rehab + Nursing Center Silver Spring moritgomer y 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth (Month, Day, Year, 5-12-1918 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days #**X**M 2□ F 8 025-03-2245 Director maine Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Itame 23s or 28s-f ehow eny Injury or other traumatic event, I'm Medical Examples marked. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits silver Spring 1 Tyes 2 No Director Montgomeru MD 10i. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20910 2015 East West 12. Was Decedent Ever in U.S. Armed Forces? USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 BYes 2 No If Yes, Give Year or Dates: 1941-1961 1 Never Married 2 Married 1 Yes 2 KNo Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Officer Airtorce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Perrau John Joseph Burke Edmee Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Phinney 15 Elmtree Rd. Billerica, Sister 0182 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 5-18-2006 BeHsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Roupp Funercul + Chemotion 21. Signature of Funeral Service Licensee PMO135 SCRVICES -Ave. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner Gangrene Right Foot Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner page 2 should be deteched for use as the burial-transit Peripheral Vascular Disease Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 🗌 Inpatient ē 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this certificate After death. filled in by the Director within 24 hours a
To the Funeral E
completely filled in Medical To the

Baltimore, Maryland 21215-0036

State

6

29a. Certifier

29b. Signature and title of certifier

MAY 1 9 2006

Registrar

DHMH 17 Rev 1/2001

Alan R. Segal 1500 Forest Glenka. Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

32. Registrass Signature

33. Registrass Signature

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D52261

29d. Date signed (Month, Day, Year)

5-13-06

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	•		For State	State of Maryland		artment of Health and M rtificate of Death		/ IIII	6 158AL
			Registrar 1. Decedent's Name (First, Middle, La	et)	Cei	lineale of Dealit	Re 2. Date of Death	g. No.	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or Location of Death	1 10(3)	4c. County of De	
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Н	Funeral		5. Social Security Number 6.3	Sex 7. Age (In yrs. last		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreign Country)
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and		Be	17. Father's Name (First, Middle, Las			18. Mother's Nam	,	ŕ	
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ā,	Health Health tam 27 other tr		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of		20c. Location - City of	
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ă	Depa impo eny i		1 Well	1 frel W//		Duda-Ruck Funeral 7922 Wise Ave. Du	ndalk,	Dundalk, Maryland	Inc. 21222
н			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the leath.		er the mode of dying, such as cardiac		est,	Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition	Muncardia	1 :	Infarction			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequer	nce of):	Infarction cry Disease			1 -10415
П	Examiner	_	Sequentially list conditions,	6. Coronary	Arte	ry Disease			15 years
Т	ed sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	nce of):				
	be executed iclen and burial-kansit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):				-
2	te be executed ysiclen and he burial kansit	calE		d					
200	thet the death certificate ed by the attending phys detached for use as the	ledic		- U.					
X P P	death certificat e attending phy id for use as th	In/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		∃Ectopic pregnancy		23d. Date of d	elivery
מ	deat death	sicia	in the past 12 months?	4 Pregnant at time of deat		Other (specify)		Month	Day Year
r Ö	net the	by Physician/Medi	9 Unknown				OG- Didash		4. 15
က်	The law requires thet the sate has been signed by the page 2 should be detached.	by	Part II. Other significant conditions Diabetes mel	Contributing to death but not resulti Litus	ng in the u	nderlying cause given in Part I.	23e. Did tob	~	to the cause of death? Probably 4 _Unknown
Ö	neen	eted		11143					
Vital Records,	The law ate has b	Completed	HyperTension				24a. Was ar autops perforn	y prior to	autopsy findings available completion of cause of
<u>=</u>	ician; Th certificate rector, pag			art Failure			1 ☐ Yes 2	YNo 1□Y	s 2□No
5	Physician; r this certifica ral director, p) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ EF	2/0. 4	1	h (Check only one		
ö	g Phy ar this eral d	. To	27. Manner of Death		Bb. Time o		28d. Describe ho	nce 6 Other (Sp w injury occurred	oecity)
Division	ath. T: Atte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	Work? M 1 □ Yes 2 □ No			
<u> </u>	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		e, farm, str	reet, factory, office	28f. Location (Sti City or Town		Rural Route Number,
5	rs afte	Cer		building, etc. (opeany)					
	To the Hospitel or Attending Pr within 24 hours alter death. To the Funeral Director: After it completely filled in by the funeral	Medical	(Check only 2 Medical Exa	miner: On the basis of examination	edge, deat n and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the ca	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	thin 2 the mplei	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License number	29	9d. Date signed (Mo	oth Day Year)
)	F 3 F 8			in M. 1: 1 7	1				
'	10 4		30. Name and address of person who	completed cause of death (Item 2	3a) (Type	RES-000	1	1ay 13,	2004
	/		Nadeen Hosein L				aruland	21224	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Black	ue, Baltimore, M	J	/	
35	Registi	ar	MAY 1 9 200	6 Blocker At 1	100				

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Maryland		nt of Health a te of Death		giene Reg. No. 200(5 1580
Physician	Decedent's Name (First, Middle, Last)	R	ENNER		2. Date of De Month	Day Year	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give s JOHNS HOPKINS BA		4b. City	Town, or Location of	of Death	4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 218-06-9014	7. Age (In yrs. ia		r 1 Year If Under	24 Hrs. 8. Date of Bi Min. (Month, Da	ay, Year) Co	nplace (State or Foreign untry) ryland
Inyland show	Usual Residence of Decedent 10a. State 10b. County		, Town or Location		oundalk		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
vith the Mar	Maryland Baltin		10f. Z	p Code	Dundalk	10g. Citizen of What Co	
deeth v	7904 St. Gregory I 11. Marital Status 1☆ Never Married 2□ Married	2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 1 No			gin? (Specify Yes or No., Puerto Rican, etc.)		ncan Indian,
by Br.	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	If Yes, Give Year or Dates:	1 ☐ Yes 16a. Decedent's Us (Give kind of w	ual Occupation		Specify: 1	White Industry
드 - 펠 -	Elementary/Secondary (0-12) 8 Years	College (1-4or 5+)	lite. DO NOT	ker	er's Name (First, Middle	Own Home	e
9 2 2 2	17. Father's Name (First, Middle, Last) Robert Lee Benne]	Patricia An	n Posluszny	
as 1 end 2 should both Heelth and Menti (Item 27 is marker rother treumatics	19a. Informant's Name/Relationship (Type Carmita Barrett (Daughter)	7904 St.	Gregory I	Drive Dund	per, City or Town, State, Z lalk, Maryla	nd 21222
Peges 1 on He nent of He nut; if item ury or oth	20a. Method of Disposition 1 Burial 2X Cremation 3 R 4 Donation 5 Other (Specify)	amoval from State	ace of Disposition <i>(N</i> emetery, crematory of 11top Serv	other place)	Date 5/17/2006	Towson, M.	1000
permit. Peges : Department of F importent: if its any injury or of ang.	21. Signature of Prineral Service License	Fully			ral Home: of Dundalk,	Dundalk, I Marviand 21	nc. .222
Physician	23a. Part1. Enter the sease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caus the death e cause on each ine.	Do not enter the m	de of dying, such as	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
/Medical Examiner		Due to (or as a consequence). **Due to (or as a consequence).	B.				
ate be executed hysicien and he burial-transit	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequent of the consequent of	ience of):	MASIC			
nrificate being physicie as the burnand	IF FEMALE:			HOSIS			
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours elter death. To the Funarial Director: After this certificate hes been signed by the attending physicompletely filled in by the funaral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic			23d. Date of del Month	ivery Day Year
wrequires that the de been signed by the a should be detached to leted by Physic	Part II. Other significant conditions con	atributing to death but not resu	ulting in the underlying	cause given in Part	_	tobacco use contribute to	
The law requir	HEPATIC EN	CEPHALOPA	THY		24a. Wa auto per 1 □ Yes	opsy prior to death?	topsy findings available completion of cause of 2 No
hysicien his certifi I director		lospital:	ER/Outpatient 3 🗆	Othor	e of Death <i>Check only</i> ursing Home 5 Res	one) sidence 6 □Other (Spe	cify)
Attending Ph or death. ector: Atter th by the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?		how injury occurred	
To the Hospital or Attending Physicien: The I within 24 hours elter death. To the Funaral Director: After this certificete he completely filled in by the funeral director, page	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact	ory, office		(Street and Number or Ri own, State)	iral Route Number,
n 24 hound n 24 hound n 24 hound no Funding file pletely file edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death occurr tion and/or investigati	d at the time, date a on, in my opinion, de	nd place, and due to the ath occurred at the time	e cause(s) and manner as o, date and place, and due	stated. to the cause(s)
To the within To the comp	29b. Signature and title of certifier	0.4	1	9c. License number		29d. Date signed (Mont	h, Day, Year)
21	30. Name and address of person who of		1 23a) (Type, Print)	RES- DO W HEDICK		May 12,2	RN AVENUE
State Registrar	31. Date filed (Month, Day, Year) MAY 1 9 2006	32. Registrar's Signa	ture				

DHMH 17 Rev 1/2001

Registrar

			1 - State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death		the G O	15805
			Registrar 1. Decedent's Name (First, Middle, Last)		erincale of Dealif	2. Date of Death	g. No .	3. Time of Death
	Physici		Mari	BRODA		Month MAY	Day Year	5:45P M
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat		4c. County of Death	0 101.
	LXamii	C1	8623 Rich mo	NO AUR	PACTIMORE		BALTIM	ORIT
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		8. Date of Birth (Month, Day,		place (State or Foreign
	Director		212-10-25/6	M 210 F Yrs.	Mortus Days Hours Min.	2-8-1	9 ITI	ALY
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits
	Aaryli F sho	ō	115	_				1 ☐ Yes 2 ☐ No
	28a-	ect	MD BALTIN 10e. Street and Number	OPE DITO	101. Zip Code	10	g. Citizen of What Cou	intry?
	3a or	٥	8623 Richmon	al Aire	21234		1)5A	,
	ms 2	Funeral Director		12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ameri	
9	or Ita	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	to Hican, etc.)	Black, White,	, etc.
ဗ္ဗ	72 hours after death with the Maryland "naturel", or Itams 23a or 28a-f show olical Examinar must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:	ты төз гырчо эрөспу.		Specify: W	nite-
21215-0036	72	Completed	15. Decedent's Educ (Specify only highest grade	ration 16a. Dec completed) (Giv	edent's Usual Occupation ve kind of work done during most of wo. DO NOT use retired)	rking	6b. Kind of Business/Ir	ndustry
12	within ene than "	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	V (a a a a /) a i a u		Inada F	70
	Hy B		17. Father's Name (First, Middle, Last)	1 90	18. Mother's Na	me (First, Middle, M.	aiden Sumame)	09
an	Mental Mental arked o	To Be	Venchenzia	O. Corso	,	adoRE		_
Maryland	should and Men Is marke eumatic	-	19a. Informant's Name/Relationship (Ty)		iling Address (Street and Number or Ri	-	City or Town, State, Zi	p Code)
Š	DEP#		Vicainia Lucas	5- Daughter. 862	3 Richmond +	UC BALL	TIMORE M	0 21234.
Jre,			20a. Method of Disposition	20b. Place of Disp	position (Name of rematory or other place)	Date 2	0c. Location - City or T	
Ē	Pag nent ent: I		1 🗹 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	Cardeus C	FFO: HOOM. 5/2	0.10L K	Cosedale	MA
Baltimore	permit. Page Depintment of Importent: If any injury or once.		21. Signature of Funeral Service Ligense	e	22. Name and Address of Facility	CTIMORE	MD 212	34.
_	20 5 2 9		* Kimberly W.	aviotay E	EVANS FUNDRAL	HAREL &	800 HARFO	RORO
į.			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	cations that caused the death. Do not e	inter the mode of dying, such as cardia	or respiratory arres	st,	Approximate Interval Between
뿔	Énysician	S 11	disease or condition		r Accident-lacu			MoS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	, ,			Tas I
	2,4,1111.101	_	Sequentially list conditions, b	Dementa C (Due to (or as a consequence of):	dysokagia			YK
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding death), and	20 11				
	al-trai	xar	that initiated events cresulting in death) Last	Due to (or as a consequence of):				416
68760,	icate be executed physicien and s the burial-transit	edical		Huge tension				4R.
.89	ifficate g phy as the							1
XO	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3			23d. Date of deliv	ery
ω.	deat	sicia	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.0	at the de by the stachad	hy	9 🗆 Unknown					
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	þ	Part II. Other significant conditions con		underlying cause given in Part I.		acco use contribute to t	
Records,	w requir been si should I	Completed	MENCY INSUIT	Ficiency		1 🗆 Yes	2 No 3 Prol	bably 4 Unknown
Sec	e law has b	nple	Osteoarth	ritis		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
a F	: The cate has					perform 1 Tes 2	ed? death?	212 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	Other	ath (Check only one,		
of	Phys r this ral di	. To	1 ☐ Yes 2 ☑ No	1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury 28b. Time	GIL 3 DOA 4 INUISING P	lome 5.4 Residen 28d. Describe how	ce 6 Other (Special	fy)
O	th. After tuner	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		203. 5000.150 1101	injury cocurred	
Division	Attending r death. ector: After by the funer	ifica	3 Suicide 6 Could not be	28e. Place of Injury · At home, farm, s	street, factory, office	28f. Location (Stre	eet and Number or Rura	al Route Number,
ā	al or	Certification:	4 Homicide determined	building, etc. (Specify)	·	City or Town,	State)	
?	To the Hospital or Atlandi within 24 hours after death. To tha Funeral Director: A completely filled in by the t		29a. Certifier (Check only 2 Medical Examin	sician: To the best of my knowledge, dea	ath occurred at the time, date and place	, and due to the cau	use(s) and manner as s	stated.
	the Hin 24 tha Fu	Medical	Unity .	ner: On the basis of examination and/or i and manner stated.	investigation, in my opinion, death occu			
	With To T	Σ	29b. Signature and title of certifier	D:110 m	29c. License number	a	d. Date signed (Month,	
,			· willing,	recently 1117	D5 4749		5/18/00	Ce.
		18	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	e, Print)	210 6.	3.5	110 712 20
			31. Date filed (Month, Day, Year)	MD & Kolling 32. Registrar's Signature	ig crossia, #	DU/ NA	CTIMORES,	Mediado
	Sta Registi		MAY 1 9 2006	Berne Lo Lon				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1:40P.M 2006 Brzezenski May Henry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eastpoint Nursing Home Eastpoint Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

O 1 Vre Months Days Hours Min. 8. Date of Birth NOV21, 1914 5. Social Security Number 6. Sex **Funeral** 9. Birthplace (State or Foreign 220-01-3014 91 Maryland Yrs Director Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28e-1 show treumatic event, the Medical Examena must be redified at 1 ☐ Yes 2 →No Director Baltimore North Point 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 4211 North Point Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Importent: if tiem 27 is marked other the any injury or other treumatic event, that once. Machine Operator Beth Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Brzezenski Golombowski Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Lohman/Daughter 4211 North Point Road Baltimore, Md.21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus Cem 5-20-06 Baltimore, Md. ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Kaczorowski Funeral Home P.A. tuloT 21222 1201 Dundalk Ave. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hear **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of physician and the burial-transit Hospitel or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Nunknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? elites fort with O Steonyelitis performed 210 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 10 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical CertIfication: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending after death. 2 Accident investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) To the 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 1 mm D1. D. 00011150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 441 SELLWOODAUE, BALTUMD 21224 TORRES, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** BRITTON LESLIE ROBERT 10 10=45A M 2006 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARPOND MEMONAL HOSPITAL HARFORD 6. Sex 1 → M 2 □ F 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 220-38-7071 1941 Director South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2X No Director Harford Havre De Grace 10e Street and Number 10f Zip Code 10g Citizen of What Country? r then "neturel", or iteme 23s or the Medical Examiner must be a 40 Robinhood Rd. Box 756 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 23 Yes 2 No
If Yes, Give
Year or Dates: 158-66 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Engine Mechanic Atlantic Aviation none other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental I Importent: If item 27 is marked ot eny injury or other treumetic ever QDCE. and Mental Dennis Edwin Britton Verdie Dorcus Silver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Robinhood Rd. Box 756 Havre De Grace, MD 21078 Lucy May Britton/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ZDonation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Wade 22. Name and Address of Facility Ronald S. State Anatomy Board 655 W. Baltimore Street mari 23a. Part 1. Enter the disease, or complications that caused in shock, on heart lailure. List only one cause on each line. Baltimore, MD 21201 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MIVLTIPLE SCIELOSIS /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ½ No autopsy performed 1□ Yes 2⊡60 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ P/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Avatural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21805 MAY 10, 2006 70. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOAD TIMONIUM MID 21093 PLABHO 2336 YONK MD 31. Date filed (Month, Day, Year) MAY 1 9 32 Registrar's Signature State 9 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 14,2006 Year **Physician** Creighton Rache1 R. 3:20am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Cheasepeake Medical Center Belair Harford If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 205-32-8541 97 Yrs Shire Oaks, PA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rithen "neturel", or items 23a or 28e-f ehov the Madical Examiner must be notified at 1 **%**Yes 2 □ No Harford Belair Directo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21015 USA 302 Temple Court Be Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ₺%o Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public Schools Elementary/Secondary (0-12) College (1-4or 5+) Teacher permit. Peges 1 and 2 should be filed w Depertment of Heelth and Mental Hygier Importent: If Item 27 I e marked other It eny injury or other traumatic event, ILIA ODG. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Plisko John Roman ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Temple Gt. Belair mo 21015 William Creighton / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May, 18, 2 Cremation 3 Semoval from State 1 Burial McMurray.PA Forest Lawn Gardens 4 Dona of Funeral Service Licensee 21. Signatur 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave Paltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Myocardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.
To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State

Hygiene.

800312 Baltimore,

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Records,

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Division

Creignton

Kesin 1 Pay, Year) 1 9 2006

29b. Signature and title of certifier

North Ave. Bei Air, Md. 21014 YN CH 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

235012

29d. Date signed (Month, Day, Year)

may 14, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

	1	For State Registrar	State of	Marylan		artment of F	lealth and N <i>Death</i>		giene Reg. No. 🥍	2006	5810
Physician		. Decedent's Name (First, Middle, Rosalyn	Covingto	on Car	mpbell			2. Date of De Month May 14	Day	Year	3. Time of Death 12:10amm
/Medica Examine	4	a. Facility Name (If not institution, p		ber)		4b. City, Town, o	r Location of Death		4c. Co	unty of Death ince G	eorges
/ Funeral		5. Social Security Number 216–54–7030	. Sex 7 1 ☐ M 2 5 F	. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year) bev 27,19	Cour	place (State or Foreign ntry) OTO CO, SC
Aaryland f ahow	-	Joe Periodence of Decedent 10a. State 10b. County 10b. DC 10b. County 10b. County	of Columbia		ty, Town or Lo Washing						10d. Inside City Limits 1 Yes 2 □ No
with the Mar	2	Oe. Street and Number 461 H. North Wes	t Apt. 619			10f. Zip Code 200	01		10g. Citizen	of What Cou	ntry?
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or Items 23a or 28e-1 show other traumatic event, the Madical Examination must be notified at		I1. Marital Status 1 □ Never Married 2 □ Marne 3 ★Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	es? 2 (24) 0		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, pecify: B.	
21215-0036 d within 72 hours at giene. er than 'natural', or the Medical Exemi	Collibration	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-	4or 5+)	(Give	DO NOT use retired	during most of work		_	of Business/In urance	idustry ,
Maryland de should be file the and Mental Hyg. 77 is marked other traumatic event.		17. Father's Name (First, Middle, La Graddie Covin					18. Mother's Nam Dortoh	ne (First, Middle ny Knigl		mame)	
Mary nd 2 shou alth and N 27 is ma		19a. Informant's Name/Relationshi Dorothy Mae Knight		Mother			and Number or Ru Apt 610 Wa				o Code)
O 82=5	:	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe			cemetery, crer	sition (Name of matory or other place ted Method	ist Church	May 23, 2006		ion - City or To	
Baltim permit. Pa Department Important any Injury		21. Signature of Fun ral Service Li	censee		22		ss of Facility Stevens F Fort Ave E				
8760 sate be shysicial	₹	23a. Part1. Enter the disease of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acul Due to (c b. Due to (c c. Dis	ch line. ce Myocor as a consecutive conary or as a consecutive c	cardial quence ol): Artery quence ol): Melli	Infarct Disease	ion	or respiratory a	irrest,		Approximate Interval Between Onset and Death
is, P.O. Box 6 res that the death certific igned by the attending p be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta antat time of o	aldeath 3	Ectopic pregnanc	у		230	1. Date ol deliv Month	ery Day Year
rds, P	d by P	Part II. Other significant condition	s contributing to de	ath but not res	sulting in the u	nderlying cause gr	ven in Part I.		tobacco use Yes 2	contribute to t	he cause of death?
I Rec	Completed by							24a. Was auto perf 1 🗆 Yes		24b. Were auto prior to co death? 1 \(\text{Yes}	opsy lindings available ompletion of cause of
hysicia his cer	0	25. Was case relerred to medical examiner? 1 Yes 22 No 27. Manner of Death 1 Accident investigations	28a. Date o (Month		28b. Time o	f 28c. Inju		th (Check only ome 5 ☐ Res 28d. Describe	idence 6		(fy)
Divis	Certific	3 Suicide 6 Could no 4 Homicide determin	and 286. Place	ol Injury - At h g, etc. (Speci		reet, factory, office		281. Location City or To	(Street and N wn, State)	lumber or Rur	al Route Number,
he Hospi n 24 hour ne Funer pletely filtr	Medical	29a. Certifier 1 Cartifying (Check only one) 1 Medical E	Physician: To the xaminer: On the ba and mann	sis of examin	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) an date and pla	id manner as s ace, and due t	stated. the cause(s)
To ti withi To ti	2	29b. Signature and title of certifier	DA			29c. Licens	se number		29d. Date s	igned (Month,	Day, Year)
5		30. Name and address of person w	mo completed cause oatch MD				verly MD	20785	- 3/	110	6
State Registra		31. Date filed (Month, Day, Year)	100	egistrar's Sign		de la			_		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** May 12, 2006 Della L. Craig 11:25 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 645 Queensgate Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Months Hours Min. 1 M 2 P Director 062-32-6439 66 Jun 19. Georgia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examples in other count. 10d. Inside City Limits Baltimore 1 Yes 2 No Director Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 645 Queensgate Road 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bishop Albea Mary W. Baldwin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other traconce. 645 Queensgate Road Baltimore, Maryland 21229 Gail Thomas Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/18/06 Linden, New Jersey ¹ 4 □ Donation 5 □ Other (Specify) Rosehill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that ceuse shock, or heart failure. List only one cause on each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physician and dispersion of the detached for use as the burial-translt The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? res 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Lesidence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident in by the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Diract completely filled in by 4 - Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and Ale 29c. License number of/certifie 29d. Date signed (Month, Day, Year) 10022 mpleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 1 9 2006 Registrar

		•	1 - State Registrar	State of Marylar	•	ent of Health and ate of Death		ene 200	6 15812
	Physici	an	1. Decedent's Name (First, Middle, La Esther Hel	\/	ia Da	vie	2. Date of Death Month	Day Year	3. Time of Death
}	/Medic		4a. Facility Name (If not institution, giv			ty, Town, or Location of Dea	May 1	4c. County of Dea	
			345 Bavena			altimore		N/	9
	Funeral Director		5. Social Security Number 6. S 220-22-34/0	ex 7. Age (In yrs.	Yrs. If Un Month	der 1 Year If Under 24 Hrs is Days Hours Min	. (Month, Day, Y	9. Bir	thplace (State or Foreign ountry)
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits
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	th the	Directo	10e. Street and Number			Zip Code	10g	. Citizen of What C	ountry?
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	after de or Itams miner o	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in L Armed Forces? 1 Tyes 2 No		cedent of Hispanic Origin? () pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
2-003¢	hours after tural, or Ita	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		2 No Specify:		Specify: / L	black
က်	2 2 3	olete	15. Decedent's Ed (Specify only highest gra	ide completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wo	orking	b. Kind of Business	
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and	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last,				me (First, Middle, Ma.		
_	should nd Men marke matic	ဥ	James N 21500		19b. Mailing Addr	ess (Street and Number or F	rta Number C		Zip Code)
Mary	alth an 27 is 27 is		Linda Dorane	3	_	venewood Av			
altimore,	es 1 e of Hea if Item ir othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	1 .	Place of Disposition (I	or other place)		c. Location - City or	Town, State
Ĕ	tment tment tent: I		4 Donation 5 Other (Specif	y) /4		metery 5/6	The second secon	ansdown	
Ra	permit. Departiment import any injury.		21. Signature of Fundal Service Licer	1500	22. Name	and Address of Facility	harman	- Harris	Funeral Hom
			23a. Part1. Enter the disease, or com	plications that caused the dea	th. Do not enter the m	Rei Sterste node of dying, such as cardia	ac or respiratory arrest	Da Himar	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a. CAR DIOPUL	MANAO	ARREST			Onset and Death MINUTES
4	/Medical Examiner		resulting in death)	Due to (or as a consec		KC CS I			MINDIES
	LAdimine	er	Sequentially list conditions, if any, leading to immediate	b. CONGESTIVE Due to (or as a consec		FAILURE			11.017115
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9/89	icate be executed physicien and s the burial-transi	edicai	•	d. VALVULAR	HEAR	T DISEASE			/EARS
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ň	0 00	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 Feta 4 Pregnant at time of c		s pregnancy (specify)		Month	Day Year
J.	res thet the de signed by the a i be detached f	Phys	9 Unknown						
ds,	law requires thet the as been signed by th 2 should be detache	d by	Part II. Other significant conditions of	contributing to death out not res	sulang in the underlyin	g cause given in Part i.			o the cause of death?
င္ပ	iw requires been si should I	Completed					24a. Was an	24b. Were at	utopsy findings available
Ř	The tite h	mo.					autopsy performed 1 ☐ Yes 2 🔀	d? prior to death?	completion of cause of
/Ita	nysician: Th nis certificate I director, pag	Be	25. Was case referred to medical examiner?				ath (Check only one)		
6	w =	5	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatient 3 28b. Time of		Home 5 Residence		ocify)
0	nding Phy tth. :: After this e funeral c	atlon	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	20d. Describe now	injury occurred	
Division of Vital Records,	or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not b			tory, office	28f. Location (Stree City or Town, S		ural Route Number,
_	pltel cours af		29a. Certifier 1 Certifying Ph	nysicien: To the best of my kn	owledge, death conur	and at the time, date and place	a and due to the sour	20(0) 27d =	- stated
	ne Hos na Fun netely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	ation and/or investigat	ion, in my opinion, death occ	urred at the time, date	and place, and due	e to the cause(s)
	To the Hospitel or At within 24 hours after or To the Funeral Direction place of completely filled in by	Me	29b. Signature and title of certifier	0.		29c. License number	29d.	. Date signed (Mont	
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3			30. Name and address of person who			CTR. 600 N	100:00 5-	Ra	of the Design
É	Sta	ite	31. Date filed (Mouth, Day, Year)	26 Pagietrar's Sign	ature Acade		WULFE ST	IN CITA UN	c, 1111 det 4.110
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Amend item#3,26,perim Verbal 5/19/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 05 **Physician** 3:45 AM Avon Dalley 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Marott Baltimore rive Oak GWYNN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months 212.58.4917 1**⊠**M 2□ F 0.08.195 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County other than "natural", or iteme 23a or 28a-f ehow vent, the Madical Examiner must be notified at GWUNN Baltimone Oak 1 ☐ Yes 2 XNo by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6619 Marott 21201 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 25 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sollege (1-4or 5+) 2 years Elementary/Secondary (0-12) Baltimore City School Police Baltimore City 12th grade 17 ie marked othe treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Robinson Roosevelt Dailer Pages 1 and 2 should 19b. Mailing Address (Street and Number or Pural Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship 🚄 1dol 9 Marott Drive Gwynn B. Dailley Vanessa WIP OakMD 21207 Health tem 27 Depertment of Health Important: if Item 27 eny injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Owings Mills MD Garrison Forest 05.17.06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvin Licenses 24 Name and Address of Facility Funeval Services 8728 Liberty Road Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sadde death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physicien and the burial-transit 20 Years or Attending Physicien: The law requires that the deeth certificate be executed ipetension. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate hes to lirector, page 2 si autopsy 1 Yes 2 No Director: After this certification by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours oft To the Funeral Di completely filled in the Hospitel 29a Certifies 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) Mysician 5 s of person who completed cause of death (Item 23a) (Type, Print) 5% 2/20 31. Date filed (Month, Day, Year) 36 Registrar's Signature State Grants) Registrar 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 17, 2006 May Margaret Angela Flaherty Αм 2:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holly Hill Manor Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sax **Funeral** Min. 07/207.191.2 ear) Months Days Hours 1 □ M 2 🛛 F Baltimore, MD 212-22-4564 93 Yrs. Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow any hjury or other treumatic event, the Modical Examinar must be published at ODE. 1 ☐ Yes 2 → No Maryland Harford Forest Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1801 Alpine Drive 21050 U.S.A. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Person Retail 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James G. Flahertv Alice M. McMahon ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Uzmed -Godchild/P.O.A. 1801 Alpine Drive Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 5/19/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Francisco Licensee Charles F. Miner Jr. 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Atherosclerotic Pnysician Cardio Vasu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the condition of the cause of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, if any leading the conditions, if any leading the conditions, if any, leading to the conditions, if any, leading to immediate the conditions of the condition Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ cete hes been signi, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 3 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mian - Dor 031865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bactimore N. Entaur Km 206 821 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 9 2006 Registrar

			For State Registrar	State of Marylan	•	nt of Health te of Death		ygiene Reg. No. 2006	15815
	Physici	an	Decedent's Name (First, Middle, Last)		000		2. Date of I	Death Day Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give st 2325 W. Hollin	reet and number) as Street ap		y. Town, or Location		11, 2000 4c. County of Dea	7
	Funeral Director		5. Social Security Number 6. Sex	M 2□F 7. Age (In yrs.		er 1 Year If Under		Birth (29, 1927 N.C. (20)	thplace (State or Foreign ountry) RTH CAROLING
	e Maryland 8a-f show	Director	10a. State 10b. County MARYLAND N/	A 10c. City	y, Town or Location	ALTIMOR	RE CIT	-ý	10d. Inside City Limits 1 ✓ Yes 2 ☐ No
カバ 午が 1036	within 72 hours after death with the Maryland ane. Then "natural", or Itama 23a or 28a-f show the Marylan Examiliter must be molified at	by Funeral	10e. Street and Number 2325 W. Hou 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 — Yes Giv No Il Yes, Give Year or Dates:	3. 3. Was Dec	edent of Hispanic Or eacry Cuban, Mexica	2.23 igin? (Specify Yes or I n. Puerto Rican, etc.)	10g. Citizen of What Co	A . erican Indian,
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4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAY 1 9 2006	32. Registrar's Signa	Lower				

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Funeral Director	ó	Social Security Number 116-36-8649 Sual Residence of Decedent	6. Sex N Ø M 3		(In yrs. las	st birthday) Yrs.	If Unde Months		If Under 24 Hr Hours Min		ate of Birth Ionth, Day,	Year) 1933	9. Birthp Cour	lace (State or Foreign try)	
Maryland f ahow	10	Da. State 10b. County	1			TownorLo							1	0d. Inside City Limits 1XYes 2 □ No	
or 28a-	10	De. Street and Number	/A		Su	CC 11Y1		p Code			10	g. Citizer	of What Cour	ntry?	_
interiore, interpretation ZTZ 13-0030 init. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland arment of Health and Mental Hyglene. orient: if item 27 is marked other than "natural", or items 23s or 28s-1 show injury or other traumatic event, ire Medical Eventual percoulled at a light of the fired at TORO Completed by Europe in Director.		2114 Ed.m 1. Marital Status 1 Never Married 2 Mai	12. W	/as Decedent Emed Forces?					anic Origin? (Mexican, Pue	(Specify Yearto Rican,	es or No- etc.)		Race - Americ Black, White,		
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To the within To the compl	2	9b. Signature and title of certify	b r	PHYSI	CIAT		(272		M	AY	gned (Month,	2006 A	
2	3	0. Name and ad this of person	who comple	n IAA	eath (Item 2	23a) (Type,	Print) &	1310 100	old 215TC	Con	M	as a a	AD 1133		
State Registra		1. Date filed (Month, Day, Year MAY 1		32 Registra	r's Signatu	ге	selles	<i>y</i> • <i>'</i>				, 0			rende

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month 9:43A M Kanald 5 06 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE NIA VAMEdiCAL CONTOR BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Yrs. June 20, New York 094-38-8743 58 1947 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Blue Spire Circle 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1964 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Transportation Bus Driver 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ormond Griffith, Jr. Roslyn Deborah Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shannon Griffith 1165 Decatur St., Brooklyn, NY 11207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Calverton Nat. Cemetery 5/12/06 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn, NY 22. Name and Address of Facility
Grace Funeral Chapel
607 N. Conduit Blvd., Brooklyn, NY 11208 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hepatic disease or condition resulting in death) Due to (or as a consequence of): epatorenal Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

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page 2 should be

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To the Hospital or Attentions within 24 hours effer death.

To the Funeral Director: After this certification that Funeral director.

or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

10a. Slate

Funeral Director

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Completed

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Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Daperment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "netural; or itema 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examiliar must be notified at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 Inpatient

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

1 Yes

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 1 ☐ Yes 2 ☐ No Place of Injury - Al home, farm, street, factory, office building, elc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 🗌 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. Countries and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) MAY 1 9 2006 State Registrar

10NGREENE STREET BALTIMURE MD 21201 MD 32. Registrar's Signature

			1 - For Stata Registrar	State of Maryla	and / Depa	artment of rtificate o	Health and f Death		jiene 2	06 158 18
-11	Physici /Medic		TODDELLE WARE				ΔY	2. Date of Dea Month MAY	Day 17,	3. Time of Death 2006 12:10P M
idia	Examir		4a. Facility Name (If not institution, give	DRIVE APT		, or Location of Deat		4c. County	ol Death	
e gr	Funeral Director		5. Social Security Number 6. Security Number 215–12–7485 Usual Residence of Decedent	X 7. Age (In y	rs. last birthday) 83 Yrs.	Il Under 1 Yes			Year)	9. Birthplace (State or Foreign Country) MARYLAND
	e-f ehow	ctor	10a. State 10b. County MD BALT	IMORE 10c.	City, Town or Lo		SSEX			10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	with th	Director	10e. Street and Number	DDTIE ADE	224	10f. Zip Code		1	0g. Citizen of \	
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentat Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	d by Funeral	1900 GROVE MANOR 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	1	Was Decedent of Yes, specify C	21221 of Hispanic Origin? (Suban, Mexican, Puer of Specify:	Specify Yes or No- to Rican, etc.)		e - American Indian, k, White, etc.
21215-0036	filed within 72 h Hygiene. Ather than "natu ent, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use ret	ne during most of wo		ESSEX 8	usiness/Industry MARTINS VELERS
Maryland	2 should be filled within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) ARTHUR	GRAY			INA	me (First, Middle, i	(PAI	RDUE)
	and 2 sh salth and n 27 ls m		19a. Informant's Name/Relationship (TDORIS SOBUS/DAUGH			ng Address <i>(Stre</i> LEFLAN D	eet and Number or Ri COURT	ura <i>l R</i> oute Number BEL AIR,		State, Zip Code) 21015
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 it any injury or other tra ghcs.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		natory or other p	olace) CEM. 5-20		20c. Location -	City or Town, State
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licen:	see			dress of Facility CV	ACH/ROSED		VERAL HOME
6	Physician physicien and physic	Examiner	23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a con: Due to (or as a con:	EROSC sequence of): PRONA sequence of): +YTER	LERO PY	DISE	LEART	DIS'EA	Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be deteched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	etal déath 3 Dideath 5 Dideath	Ectopic pregnar		23e. Did tot	Мо	e of delivery th Day Year bute to the cause of death?
Records,	aw requires ss been sign 2 should be	Completed by						1 ☐ Ye	es 2 No	3 Probably 4 Unknown Vere autopsy lindings available
ital Re	sician: The law s certificete hes b irector, page 2 s	Be Com	25. Was case relerred to medical				26. Place of Dea	autops perform 1 Yes 2 ath (Check only on	ned2 c	rior to completion of cause of eath? ☐ Yes No
Division of Vital	Phy ral d	ို	examiner? 1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury	28c. In	Other: 4 Nursing H	lome 5 Reside	ence 6 ⊟Othe	
Divis	itel or Attending is after death. all Director: After led in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	ecify)			City or Fown	i, State)	er or Rural Route Number,
	To the Hospitel within 24 hours and to the Funeral completely filled	Medical	one)	rsician: To the best of my iner: On the basis of examand manner stated.	knowledge, deatl nination and/or in	occurred at the restigation, in m	time, date and place y opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and ma ate and place, a	nner as stated. and due to the cause(s)
	y Kith	2	29b. Signature and title ol certifier	arshell		D	4000 (8	5/1	(Month, Day, Year)
10	1		30. Name and address of person who of TIM PARSHAL	ompleted cause of death (fram 23a) (Type,	Print) KCN	SQUAR	E DR	BALTO	MORE MD
	Sta Regista	_	31. Date filed (Month, Day, Year) MAY 1 9 2	32. Registrar's Si	gnature	rast 1				

DHMH 17 Rev 1/2001

			1 - State Registrar	ate of Maryla		artment of F			giene Reg. No. 2006	1581	
	Physici		Decedent's Name (First, Middle, Last) Ida Mae Gartre	211				2. Date of Dea Month	ath Day Yeer	3. Time of Death	
}	/Medic Examin		4a. Facility Name (If not institution, give street Carroll Hospital				r Location of Death		4c. County of Death		
	Funeral Director		5. Social Security Number 215-26-1220 6. Sex 1 □ M		rs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan •	7. Year) 9. Birth Cou 17, 1931 Ma	place (State or Foreig ntry) ryland	
	death with the Maryland me 23e or 28a-f ehow roust be notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	10c.	City, Town or Lo	esville				10d. Inside City Limits	
	h with the	al Director	10e. Street and Number 1442 Buckhorn Road	l		10f. Zip Code 21	784		10g. Citizen of What Cou United Sta	•	
036	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other then "naturel", or Iteme 23e or 28e-f ehow marked other then "naturel", or Iteme 23e or 28e-f ehow marke ovent, the Medical Examinar must be notified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in med Forces?. □ Yes 20 No Yes, Give ear or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 25(No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	acify Yes or No- Rican, etc.) 14. Race - Americ Black, White, Specify: W		
Maryland 21215-0036	within 72 ho ene. then "natur ne Medical	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)		(Give	dent's Usual Dccup kind of work done DO NOT use retired OUSEKEED	during most of world)	king	16b. Kind of Business/Ir Springfield		
/land 2	should be filed within 72 and Mental Hygiene. I marked other then "nat umatic event, the Medic	To Be Co	17. Father's Name (First, Middle, Last) John Wesley Ster	n				Maiden Sumame)	aiden Sumame)		
	1 and 2 sho Health and I Ism 27 is mu		19a. Informant's Name/Relationship (Type, F Charlotte Sautter	Daughter	225	35 Armstı	ong Terr	Rural Route Number, City or Town, State. Zip Code) 2014 race Unit 109 Ashburn, VA			
Baltimore,	Pages ent of nt: If it		20a. Method of Disposition 1 Burial 200 cremation 3 Remort 4 Donaton 5 Other (Specify)		South Ca	rroll Cre	ematory M			eld, MD	
	Physician /Medical Examiner	ai Examiner	21. Signal troof Funeral Service Licensee 21a. Part. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	ise on each line	eath. Do not ent CH sequence of): CBSTR sequence of):	212 W. O	d Libert g, such as cardiac 2571AA	y Road or respiratory ar TORY	ne & Cremato Winfield, N rest. =4(LURE DISEASE	Approximate Interval Between Onset and Death	
9	ath certif ttending or use as	Physician/Medical	in the past 12 months?	yes, outcome of pre □Live birth 2 □ F □ Pregnant at time o □ Unknown	etel death 3	Ectopic pregnancy	,		23d. Date of delive	ery Day Year	
rds, P.	w requires that the dei been signed by the a should be detached fi	<u>م</u> ا	Part II. Other significant conditions contribu				en in Part I.	23e. Did to	obacco use contribute to t	he cause of death?	
al Reco	: The law recete hes be	Completed	COAGULOPAT	ну					an 24b. Were auto sy prior to co death? 2 No 1 Yes	opsy findings available impletion of cause of	
Division of Vital Records, P.O. Box	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	2 Accident investigation	a. Date of Injury (Month, Day Year		f 28c. Injur Wor M 1 🗆	4 Untursing n	ome 5 Resid	lence 6 Other (Speciliow injury occurred		
DIV	pital or At ours after o erei Direc filled in by		4 Homicide determined	building, etc. (Spe	9cify)			City or Tow			
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Af completely filled in by the fur	Medical	(Check only 2 Medical Examiner:	n: To the best of my On the basis of examind manner stated.	nination and/or in	h occurred at the tir vestigation, in my o	pinion, death occur	red at the time, o	cause(s) and manner as sidate and place, and due to 29d. Date signed (Month,	o the cause(s)	
	4		30. Name and address of person who comple	ted cause of death fi	(tem 23a) (Tyre		0263	200	05-18-07	6 1 AVE	
3	1		FRANCIS KHOO,	MD	CARROL	L HOSPIT	AL CENTE	R W	MEMORIA ESTMINSTER	2, ND 2115	

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Registrar

MAY 1 9 2006

			1 - For State of Maryland / Dep	eartment of Health an ertificate of Death		ne No2006 15820							
3	× 2	4.5	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death							
	Physicia /Medic		Mary E. Hall		May 11 2	006 Year 1441 M							
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D	eath	4c. County of Death							
22	286	ik (M	Anne Arundel Medical Center	Annapolis	Hrs. I a a	Anne Arundel							
*	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 □ M 2 ☒ F Yrs.	If Under 1 Year If Under 24	Ain. (Month, Day, Ye	9. Birthplace (State or Foreign Country) 925 Maryland							
	Director		212-52-4802 81 Usual Residence of Decedent		May 11 1	925 Maryland							
	yland		10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits							
	Mar-fet	tor	Maryland Anne Arundel Lothian	_		1⊠Yes 2□No							
	th the	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?							
	ath w 23a	rai	121 A Street	20711		USA							
	er de	Funerai		. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	(Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.							
36	irs aft	by F	1 □ Never Married 2 □ Marned 1 □ Yes 21□No If Yes, Give 31☑ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black							
Ö	filed within 72 hours after death with the Maryland Hygiene. ther then "natural; or items 23a or 28a-f show ant, it a Madical Examinant the multised at			edent's Usual Occupation	168	p. Kind of Business/Industry							
215	P. "n	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of DO NOT use retired)	Working								
2	ed will	Completed	7th 0	Cook		Restaurant							
Maryland 21215-0036	<u>e</u> = 0 ≥	Be	17. Father's Name (First, Middle, Last)		Name (First, Middle, Mai stelle Sel								
3	should be ind Mental I marked o	Ç	Freeman Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number o									
M			100	A Street LOt									
	s 1 and f Health Itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or Town, State							
altimore,	Pages nent of h ant: If Its ury or o		#2 Surial 2 □ Cremation 3 □ Removal from State Chews U		/17/06 OW	rensville, Md.							
alti	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility M. Reese & So	ne Mortuar	T. D A							
<u> </u>	89 = 9		Lavry S, Seese M004838	21 West St. A	nnapolis,	Md. 21401							
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as car	diac or respiratory arrest,	Approximate interval Between Onset and Death?							
in	Physician		Immediate Cause (Final disease or condition resulting in death) a. Couces fine free facilities a. Couces fine facilities										
1	/Medical Examiner		Due to (or as a consequence of):	,									
4		PE	Sequentially list conditions, b. Due to (or as a consequence of).										
	uted J ansit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
ó	exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):										
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	dicai	d										
9	ing pt e as t	(i)	IF FEMALE:										
Box	leath certific attending pl	ian		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year							
P.0.	that the de ed by the a detached t	Physician/M	1 Tes 2 No 9 Unknown	Citier (specify)									
	that the ned by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?							
rds	quires in sign	ed by	acute rend tuitie		1 ☐ Yes	2 No 3 Probably 4 Unknown							
S	law requir as been si 2 should I	piet	COPD		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of							
Ä	sician: The lay certificate has rector, page 2	Completed			performe	death?							
ita	sian: artifica ictor,	Be	25. Was case referred to medical examiner?		Death (Check only one)								
7	Physician: r this certific ral director.	ုင	1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpat		ng Home 5 Residence								
Division of Vital Records,	tending Physician: The Beath. tor: After this certificate hi the funeral director, page	lon	27. Manner of Death 1		28d. Describe how	injury occurred							
İSİ	or Attending after death. Director: After in by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At home, farm,			et and Number or Rural Route Number,							
2	\$ # 5 ⊆	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)							
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier (Check only [Check										
	To the H within 24 To the Fi complete	ledical	one)										
	Vit To Con	Σ	29b. Signature and title of centifier	29c. License number		Date signed (Month, Day, Year)							
7	4		Jef / Jeluson my	D24809		-11-2004							
0	L'		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	A.A.A.C.	les 146/21401							
17 mg	Sta	ate		1 11 1000	- The state of	43/7-1-1							
*	Regist		31. Date filed (Month, Day, Year) MAY 1 9 2006 32. Registrar's Signafure	CENTE	U								

DHMH 17 Rev 1/2001

		4	For State Registrar		State o	f Maryla	nd / Depa <i>Ce</i>	artment rtificate			nd Me	ental Hy	giene Reg. No.	006	15	321												
			1. Decedent's Name (First, Mid			-					1	2. Date of De		Year	3. Time													
	Physici /Medic		KATHERINI	EL	ORRA	INE	HAMIL	_				MAY	18	2006	940	Ам												
	Examin	er	4a. Facility Name (If not institut	-		m <i>ber)</i>				Location of		IRYLA		County of Death	i													
			HARBOR H	6. Sex		7. Age (in yr:	s. last birthday)	If Under		If Under 2				9. Birth	place (State	or Foreign												
	Funeral Director		215 60 4757		M 2DF	54		Months	Days	Hours		8. Date of Bi (Month, Di 1/20/1		Cot	intry) ` _MD													
	Du ,		Usual Residence of Decedent 10a. State 10b. Cour	ab.		100.0	ity, Town or Lo	vation							10d. Inside (ity Limits												
	farylan show	o o		/A		100.0	only, rount of L		timo	re Ci	.ty					s 2∐No												
	the N	Director	10e. Street and Number					10f. Zip	Code				10g. Citiz	en of What Cou	intry?													
	urs after death with the Maryland 'al', or Items 23a or 28a-f show Examical must be rollind at	aiD	38 Heath S	treet						21	230			Ţ	JSA													
		Funeral	11. Marital Status		Armed Fo		U.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cubai	spanic Orig n, Mexican,	in? (Spec Puerto R	ity Yes or No lican, etc.)	o- 1	 Race - Amer Black, White 														
36	hours after tural', or ite al Evamina	by Fu	1 ☐ Never Married 2 ☐ Widowed 4 ☐ Divorce		1 ☐ Yes If Yes, Gir Year or D	ve		1 ☐ Yes 2	No 🄀	Specify:				Specify: W	nite													
9			15. Dece	lent's Educ	cation		16a. Dece	dent's Usua	Occupa	tion			16b. Kir	d of Business/l	ndustry													
215	100	Completed	(Specify only hig Elementary/Secondary (0-12		College (1-4or 5+)	life.	kind of wor DO NOT us	e retired,	,	or working	g																
121	filed within Hygiene other than vent, the M		9 17. Father's Name (First, Midd	lo (ast)	0			H	omen	aker	's Name	(First, Middle	Maiden	Sumama)	Own H	Ome												
lanc	a d a	To Be	Frank Jowan		h							t Carr		Juname)														
Maryland 21215-0036	and and ts m		19a. Informant's Name/Relation Rodney W. Hai					_{ng Address} Heath	,			Route Numb		Town, State, Z. 21230	ip Code)													
ē,	s 1 ar of Hea Item		20a. Method of Disposition	- 7-		1	Place of Dispo			9)	Da	ite	20c. Loc	ation - City or 1	own, State													
Ē	Page nent c ant: If ary or		1 Surial 2 Cremation 4 Donation 5 Other		emoval from	State H	oly Cro	· ·			5/2	3/2006	Ba.	ltimore	MD													
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr 20058.		21. Si naly of Funere 20	-	Victo	or P. D	oda (s L.	Stev	ens i			me, Inc.														
	Pnysician		23a. Part1. Enter the disease shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)	or compli ist only on	ie cause on e	caused the de each line. SEPSI		ter the mode	of dying	g, such as o	cardiac or	respiratory a	irrest,	1	Onset and	etween												
7	/Medical Examiner		rosuming in death)		Due to	(or as a consi	equence of):	Α								- HOUR												
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to	(or as a cons									W CLE	1100.0												
12	ecuted and I-transit	Examine	that initiated events	1.	·	COPD									20 41	PARS												
8760,	cate be executed obysician and the burial-transit		resulting in death) Last		Due to	(or as a conse	equence of):																					
87	physical physics	dicai		0	1																							
.O. Box 6	The law requires that the death certifit to has been signed by the attending to age 2 should be detached for use as	Φ .						a a	a a	a a	a a	O .	Φ .	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2	1 Live I	tcome of preg pirth 2 Te nant at time of lown	ital déath 3[⊒Ectopic pre ☐ Other (spe					2	3d. Date of deli Month	/ery Day	Year
<u>α</u>	uires that the signed by id be detacted								en in Part I.		23e. Did tobacco use contribute to the cause of																	
Vital Records,	w requ	Completed				EDIN (Ś					24a. Was	an	24b. Were aut	opsy finding	s available												
Re	The lav	omp										auto perf	ormed?	prior to c death?	ompletion of	cause of												
ital		Be C	25. Was case referred to med	ical						26. Place	of Death	(Check only		163	20010													
of V	d is	20	examiner? 1 Yes 2 No	H	_		☐ ER/Outpatie			4 LI NUI				☐Other (Spec	ify)													
o uc	ding Ph Atter th tuneral	inol.	27. Manner of Death 1 ☑Natural 5 ☑ Per		28a. Date (Mor	of Injury th, Day Year)	28b. Time o Injury	of 21	Bc. Injury Work	rat <br Yes 2 □ N		8d. Describe	how injury	occurred														
Division	Attending r death.	licat	3 ☐ Suicide 6 ☐ Coi	estigation uld not be ermined	28e. Place	e of Injury - At	home, farm, st			163 2 1	_			l Number or Rui	al Route Nu	n <i>ber,</i>												
Ο̈́	afor A after Direction	Certification:	4 Homicide	emined	build	ing, etc. (Spe	cify)	,	,			City or To	wn, State)															
	To the Hospital or Attenowithin 24 hours after death To the Funeral Director: completely tilled in by the	Medical C			ner: On the b									and manner as place, and due		(s)												
	To the within To the complete	Me		tifier	lomi	fu	/	29c		number	00		29d. Date	signed (Month	Day, Year)	6												
	6		30. Name and address of personal MA B	son who co	ompleted cau	se of death (II	em 23a) (Type	Print)	DVE	2ST	BAI	TMO	RE N	ND 21	225													
	4.30 (1.10)	ate			49					• (., , , , , ,																
	Regist	2	31. Date fled (Month, Day, Y	106	Lileur	Y 13.	nature	J																				

			1 - For State Registrar	State of Mary	/land / Dep		Health and			
			Decedent's Name (First, Middle, L.	actl		Tillicale O	Dealli		Reg. No.	
	Physic /Medi			Elsie Mar	ie Herl			2. Date of De Month 05	_	3. Time of Death 7:45 A M
	Exami	ner	4a. Facility Name (If not institution, g	ve street and number)	- 1	4b. City Town,	or Location of Deal	th	4c. County of	Death
				are Hispite	21	Kasi	dale		Bal	timore
	Funeral			Sex 7. Age (In 1 ☐ M 2√2 F	yrs. last birthday	Months Day			th (Birthplace (State or Foreign Country)
	Director		218-26-4926 Usual Residence of Decedent	75	Yrs.				23,1931	Maryland
	and *		10a. State 10b. County	10	c. City, Town or L	ocation				
2	Many	ō	Maryland Balt	imore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					10d. Inside City Limits
- \	28a-	Director	10e. Street and Number	THOLE			Rosedale	•		1 ☐ Yes 21② No
. 3	with a	ā	6308 Magdolena	Poad		10f. Zip Code	237		10g. Citizen of Wh	,
Sie	172 hours after death with the Maryland *nature!', or Iteme 23a or 28a-1 show telical Examinar must be notified at	by Funeral	11. Marital Status	12. Was Decedent Ever	in II O				United	
(7)	Her of	Ë	1 Never Married 2 Married	Armed Forces?	in 0.5, 13.	If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	ipecify Yes or No to Rican, etc.)	- 14. Race - Black,	American Indian, White, etc.
7-7	hours after turel', or ite	P P	3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 Yes 2 No	Specify:		Specify:	***** * * ·
- P	2 ho	ed	15. Decedent's 8	ducation	16a Dece	edent's Usual Occu	eation		10: 15: 1 1 -	White
25	within 72 ans. than nai	ple	(Specify only highest gi	ade completed)	(Give	e kind of work done DO NOT use retire	ed) most of wor	rking	16b. Kind of Busin	ness/Industry
Herl, 1 21215-0036	d with	Completed	8 Years	College (1-4or 5+)		memaker			Own H	ome
Þ	illed Hygin other	Bec	17. Father's Name (First, Middle, Las	")			18. Mother's Nan	ne (First, Middle	Maiden Sumame)	
<u><u>a</u></u>	Mental rked o	TOB	Albert P. Curl					e Lee Mo		
Maryland	shou ord N	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Stree			er, City or Town, Sta	to 7's Codel
Σ	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Depertment of Heelth and Mental Hyglene. Importent: If Item 27 is marked other than "naturel", or Iteme 23 ao r 28a-1 shov any Injury or other traumatic event, the Madical Examinar must be notified at once.		Mr. Marvin P. He	rl (Husband)	630	8 Magdol	ena Road	Roseda	le, Maryl	and 21237
Baltimore,	s 1 e		20a. Method of Disposition	20	Ob. Place of Disne	osition (Name of		Date	20c. Location - Cit	
Ĕ	Page ent c nt: If ry or		Figurial 2 ☐ Cremation 3 [4 ☐ Donation 75 ☐ Other (Speci			matory or other pla		5 / 5 o / 5		
Ħ	mit.		21. Signature et Fyneral Service Lice			2. Name and Addr	esus Cem.	5/19/20	006 Dun	dalk, Maryland
ä	permit. Departr Import eny Inj		* halm	InW//	þū	da-Ruck	Funeral H	ome of I	undalk, Maryland	Inc.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the	death. Do not en	7922 Wisc	e Ave. Di	undalk,	Maryland	
	Dhysisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Bronch	valveo	iar car	cinoma	of the	lung	Oliver and Double
	Examiner			Due to (or as a con	rsequence of):					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	b Due to (or as a con	sequence of):					
	be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury		, , , , , , , , , , , , , , , , , , , ,					
oʻ	le be executed /sicien and e burial-transit	Exa	resulting in death) Last	Due to (or as a con	sequence of):					
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68	The law requires that the death certificat sie has been signed by the ettending phy bage 2 should be detached for use as the	ed								
Box.	h cer andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					224 Date of	4-1
Ω.	deatl	Ca	in the past 12 months? 1 □ Yes 2 DNo	1 Live birth 2 ☐ F 4 ☐ Pregnant at time		Ectopic pregnance Other (specify)	У		23d. Date of Month	Day Year
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٠ <u>٠</u>	w requires that been signed I should be det		Part II. Other significant conditions of	ontributing to death but not	resulting in the un	nderlying cause gr	ren in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Division of Vital Records,	quire an sig uld b	Completed by						18 Y		Probably 4 Dunknown
္မ	s bee	et						24a. Was a	-	
æ	The law sete has page 2 s	E						autons	v A prior	autopsy findings available to completion of cause of
重	siclan: Th certificate rector, pag	ပိ	25. Was case referred to medical						2 No 1 0	
:	Physician: r this certifice ral director, p	10 B	examiner? 1 ☐ Yes 21 No	Hospital:		Oth	26. Place of Deat			
9	9 Ph		27. Manner of Death	28a. Date of fniury	2 ER/Outpatien 28b. Time of	I 3L DUA	4 ☐ Nursing Ho		ence 6 Other (S	Specify)
<u>.</u>	Attending r death, sector: After oy the fune	흪	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	njury (Wor	k? Yes 2 □No	Zou. Describe no	w injury occurred	
<u>K</u>	Atternation of the	<u>≅</u>	3 Suicide 6 ☐ Could not be		t home farm stre			281 Location (St	mot and Municipal	Rural Route Number,
ä	s afte	Certification:	4 Homicide determined	building, etc. (Spe	ecify)	ou radiory, diffee		City or Town	, State)	Hural Houte Number,
			29a. Certifier 15 Certifying Ph	ysician: To the best of my liner: On the basis of exam	knowledge, death	occurred at the time	ne, date and place	and due to the	uses(e) and	
	ne Ho n 24 n 24 ne Fu	Medical	(Check only 2 Medical Exam	iner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my o	pinion, death occurr	ed at the time, da	ite and place, and o	as stated. flue to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and tale of certifier	7/		29c. License	e number	25	9d. Date signed (Mo	onth, Day, Year)
	7		mort.	Klaro.	200	12	846		6/15/1	1/-
-	10		30. Name and address of person who	completed cause of death (7	Tem 23a) (Type F	Print)			2/13/6	
	/ -		Dr. Martin In	eridan 900	UFrank	lin San	ve Driva	2 Pala	HO. MI	51527
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	J. JAN	- UIIVX	uul	1.11.	MADI
	Registra	r	MAY 1 9 2006	Black of Fi	Goas	1				

Registrar DHMH 17 Rev 1/2001 06-03325

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Dorothy Lena Hoefler 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day **Medical Examiner** 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c County of Death 3612 Advocate Hill Drive Jarrettsville Harford 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth/MM/DD/YYYY 9. Birthplace (State or 6 Sex Age (In yrs. last birthday) **Funeral** Days Hours Director М 2 V F Cour Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 No items 23a or 28a-f show must be netified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married Yes 2 V No 3 Widowed Give Year 1 Yes 2 No specify. 4 Divorced ont of Health and Mental Hygiene.

11: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) 21215-0036 18 Mother's Name (First, Middle, Maiden Surname 17 Father's Name (First, Middle, Last) Be 1110 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မ 19a. Informant's Name/Relationship (Type M 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) BelAir, mD 20-06 Important: I Beltir Memorial Gardens Donation 5 Other\Specify nature of n e de Licensee 22. Name and Address of Facility vans Funeral Forest Hill, mp 21050 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause of each line. Approximate Interval **Physician** Between Onset and /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and d. Physician/Medical physician a UNPENDED **AMENDED** requires that the death certificate be Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o ģ 1 Yes 2 No 3 Probably 4 Unknown م Diabetes Mellitus Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 2 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Division Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b 29c. License number 29d. Date signed (Month. Day Year) O.C.M.E. May 17, 2006 e and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD

Registrar DHMH 17 Rev 1/2001

OCMF 2006

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHNSON ACHI MAY 0707 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6555 Woodgreen Circle Gwynn Oaks Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1□M 2XF 59 Director 227-70-8332 18, 1946Virginia Sept. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28e-f show other traumatic event, the Medical Exercities must be notified at **Funeral Director** 1 ☐ Yes 2 X No Maryland Baltimore Gwynn Oaks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 239 6555 Woodgreen Circle 21207 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ₺ Divorced Specify: **Black** 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. .nt: If item 27 ia marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Certified Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pauline Adelia Tapscott Elias S. Brooks, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Anthony Brooks 6555 Woodgreen Circle, Gwynn Oaks, MD 21207 20b. Place of Disposition (Name of Poplar Forks 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 5/10/06 Church Cemetery Warrenton, VA 21. Sign (ure of Funeral Service Licensee 22. Name and Address of Facility
Joynes Funeral Home, Inc. P.O. Box 3633 Marien Warrenton, lennis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed and to (or as a consequence of): Box 68760 igned by the attending physician be detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2□ No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this To the Hospitel or Attending Phywithin 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) tar Ford 101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2006 MAY 1 Registrar

06-03244 Please Type or Print in Black Indelible Ink Thomas Gregory Johnson State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ May 13, 2006 Medical Examiner 2302 hrs Thomas Gregory Johnson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rear of 201 Haverhill Road Joppa Harford 5. Social Security Number If Under 24Hrs. 9. Birthplace (State or 7. Age (In yrs last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY **Funeral** Months Davs Hours Min Director 40 Dec. 16, 217-98-5078 1X M 2 F 1965 Country)MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 Yes 2 X No or items 23a or 28a-f sho must be notified at once. Maryland | Harford Joppatowne Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 **USA** 417 Berkshire Ct. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: If Yes, Give Year 3 Widowed 4 Divorced Specify: White traumatic event, the Medical Examiner "natural" ģ Pages I and 2 should be filed within 72 hours a nent of Health and Mental Hygiene ant: If item 27 is marked other than "natura or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Alice Jean Tranter Ernest G. Johnson, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 417 Berkshire Ct., Joppatowne, Maryland 21085 Jeanenne M. Johnson / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Department of Important: 1 5-17-06 Bel Air, Maryland Bel Air Memorial Grdn. Donation 5 Other Specify permit ure of 22 Name and Address of Facility Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part I. Enter the disease, or complication failure. List only one cause on each line is this sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and /Medical Death a Neck injury and compression asphyxia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Physician/Medical UNPENDED AMENDED ending physician use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ဥ 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: May 13, 2006 Driver of ATV found beneath it Division Natural 2252 hrs 1 Yes 2 V No Pending 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide within 24 hours a To the Funeral I (Specify) Quarry Rear of 201 Haverhill Road, Joppa, MFD Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical onel 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29bp Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 14, 2006 Merce Name and 1 dress of person who completed cause of death (Item 23a) 0 Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of	of Marylan		irtment of tificate o		nd Mental H	lygier Reg. I		jb	151	320
			1. Decedent's Name (First, Middle	Last)					2. Date of Month		Day	Vone	3. Time of	Death
	Physicia		Margaret	Elizabeth	n Kerse	y Bup	p		May		2006	Year	1900	РΜ
9	/Medic Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		•	, or Location of	Death		4c. County	of Death		
	1,		Shady Grove Ad	ventist H	lospital		Rock	ville			Mont	gome	ry	
	Funeral			6. Sex	7. Age (In yrs.		If Under 1 Ye	ar If Under 24	Hrs. 8. Date of (Month,	Birth	20)	9. Birthp	lace (State	or Foreign
	Director		225-03-6998	1 □ M 2 🖾 F	98	Yrs.	Months Day	s Hours	Mar.			Cour	VA	
	פ		Usual Residence of Decedent											
	how I		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside C	
	B-f-	cto	VA None		На	mpton							1 XX Yes	2 🗌 No
	th the	lre.	10e. Street and Number				10f. Zip Code	Э		10g.	Citizen of W	/hat Cour	ntry?	
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	eep ee	ner	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13. \	Vas Decedent o	of Hispanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No-		- Amend	an Indian,	
٥	or Ite		1 Never Married 2 Marri		2 🔀 No		l □ Yes 2.2XIN		r derio riioani, etc.,		Specify	T 71		
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7	within 72 ene. then nai	du	Elementary/Secondary (0-12)	T	(1-4or 5+)	life. L	DO NOT use ret	ired)						
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ğ	be filed ital Hygid of other	Be	17. Father's Name (First, Middle, I	.ast)				18. Mother's	s Name (First, Midd	dle, Maid	len Sumam	e)		
<u>a</u>		2	John Edgar Ke	rsey, Sr				Kat	ie Lelia	Bur	ch			
Maryland 21215-0036	€ 5 E E		19a. Informant's Name/Relationsh			19b. Mailin	g Address (Stre	eet and Number	or Rural Route Nur	nber, Cit	y or Town,	State, Zip	Code)	
	1 and 2 Heelth a tem 27 le		Charles E. Ker Clinton W. Ker	sey/Neph	ew	700	New Ber	n Avenu	e, Hampto	n, v	VA 23	3669		
Baltimore,	tem item oth		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	olace)	Date	20c.	Location -	City or To	wn, State	
Ē	Page ent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Dopation 5 ☐ Other (Sp		State	arklawı ark	natory or other in Memori	ial 5	/15/06	На	mpton	. VA		
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			23a. Part1. Enter the disease, or	complications that	caused the deat								Approximat	ie .
			shock, or heart failure. List of Immediate Cause (Final	only one cause on	each line.			, •					Interval Bet Onset and	Death
	Physician		disease or condition resulting in death)	_ a <u>S</u>	EPS15								1 Da	1
	/Medical Examiner		,	• O	(or as a conseq								1 1 1	1.1
	3	ē	Sequentially list conditions,		reumoni							-	1 Da	7
	si ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ringly		whatha	1.0					1 Day	A
	and tran	Examin	that initiated events resulting in death) Last	C.	(or as a conseq		MECHO	ν,					. 1000	1
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Box	eath certifi attending I for use as	ician/Me	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2 Feta		Ectopic pregna	ncy			23d. Date Mon		,	Year
	he at	Sici	1 ☐ Yes 2 ☑ No	4□Preg 9□Unkr	nant at time of c	death 5□	Other (specify)			-	IVIOI	1111	Day	1 Gai
о. О	et the	Physi	9 Unknown				-							
	ires that the de signed by the a I be detached to	þ	Part II. Other significant condition	ns contributing to	death but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Di				ne cause of o	
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ā		O	25. Was case referred to medical			_		26. Place o	f Death /Check on		140	_ 163	20 140	
	Physician: r this certific ral director.	0	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	patient 2	ER/Outpatien	t 3 DOA	Other	ing Home 5 ☐ Re		6 □Othe	r (Snecifi	v)	
0	Ph.	Ë	27. Manner of Death	28a. Date	of Injury	28b. Time of		njury at Vork?	28d. Describ				'/	
0	tending leath. lor: After the funer	ig l	1 □ Natural 5 □ Pending 2 □ Accident investig	,	nth, Day Year)	Injury		vonx? □Yes 2□No						
Division of	Attending or death.	Certification:	3 ☐ Suicide 6 ☐ Could n	ned 286. Plac	e of Injury - At h	ome, farm, str	eet, factory, office	ce	28f. Location			er or Rum	l Route Num	iber,
	afte Dir din b	ert	4 Homicide determine	build	ling, etc. (Specii	(y)			City or	Town, St	afe)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifyin	g Physician: To th	e best of my kno	owledge, death	occurred at the	time, date and	place, and due to the	ne cause	(s) and mar	nner as si	ated.	
	P Ho P Fu	edical	(Check only 2 Medical 8 one)	Exeminer: On the	basis of examina nner stated.	ation and/or inv	estigation, in m	y opinion, death	occurred at the tim	e, date a	and place, a	nd due to	the cause(s	5)
	of thin of the office of the o	Me	29b. Signature and title of certifier				29c. Lice	ense number		29d. l	Date signed	(Month,	Day, Year)	
	- 3 + 0		PANAMIA	Man	77			0003	129	r	MAY.	11.2	1971-	
•	N		20 Name and address of account	who completed a	ien of doet! /li	n 22c\ /T:			'			11/6	000	
	10		30. Name and address of person	NANVA	2 NII			1 Conto	r Dr., Ro	0 1277	110	MID 0	0850	
_	C	10	31. Date filed (Month, Day, Year)	32	Registrar's Sinns			T CELLE	L DI., KO	CVVI	.116,	עניו ע	0000	
41	Sta Registi		MAY 1 9 2	106	Registrar's Signa	AS EXCLAS								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1006 CHRISTINE K KRACKELER 1406 PM Me 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A MARylord Made cal Contor Batimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 12/15/1944 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 ☐ M 2 💢 F 61 126-34-8672 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ☐ No Director Albany New York Menands 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12204 U.S.A. 11 Sage Estate Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Lawyer Attorney 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arthur R. Kirwin Arlene Duver ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert J. Krackeler - Husband 11 Sage Estate Menands, NY 12204 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 05/19/2006 Albany Rural Cemetery Albany, NY 4 ☐ Donation 5 ☐ Other (Specify) Frankerice Licensee Charles F. Miner 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signatur 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or legar faiture. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PHIMONALY Edema Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 \(\) Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, attending physicien to as been signed by the a page Physicien: within 24 hours after death.

To the Funers! Director: After this certific completely filled in by the funeral director. or Attending To the Hospitel within 24 hours a To the Funeral C Hospitel

Funeral

Director

filed within 72 hours after deeth with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic sysut, the Madical Examinar must be notified at

permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic svent 900g.

Physician

/Medical

Examiner

118 North 31. Date filed (Month, Day, Year) State 1 Registrar

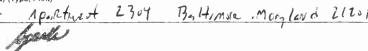
29b. Signature and title of certifier

9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MV



29c. License number

P19782

29d. Date signed (Month, Day, Year)

			Amend item#29 1 - State Registrar	ou, pestate	BrMatyl	and ^H Depa <i>Cei</i>	artment of H rtificate of L	ealth an D <i>eath</i>		jiene 2 leg. No.	005	15828
	Physici /Medic		Decedent's Name (First, Middle		nda Da:	rlene Ke	yser		2. Date of Dea Month MA		2004	3. Time of Death
	Examin		4a. Facility Name (If not institution		- 18		4b. City, Town, or				inty of Death	
			Union Memoria 5. Social Security Number	1 Hospit		yrs. last birthday)	Balti If Under 1 Year	more C	Hrs. 8 Date of Birth		/A	place (State or Foreign
	Funeral Director		217-56-9480	1□M 2🖫 F	55	Yrs.	Months Days	Hours N	Min. (Month, Day	, Year) , 1951	Cour	vland
	p		Usual Residence of Decedent 10a. State 10b. County		100	. City, Town or La			, odine 2	7235		
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212-0036	2 hour		15. Decedent	Year or		16a. Deced	dent's Usual Occupa	ition		16b. Kind o	f Business/In	dustry
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<u> </u>	should nd Mer mark matic	၉	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a	and Number o	r Rural Route Number	City or To	wn State Zin	Codel
<u>B</u>	nd 2 saith ar 27 is r trau		Mr. Donald Keys		and)		inship Ro		ındalk, Maı			
e,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation		20	b. Place of Dispo	sition (Name of natory or other place	9)	Date	20c. Locatio	on - City or To	own, State
sattimore,	Pag ment tant: h		4 □ Donation 5 □ Other (S)		III State	Hilltop	Service C	corp. 5			-	ryland
Dan Dan Dan Dan Dan Dan Dan Dan Dan Dan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depirtment of Healin and Mental Hygiene. Depirtment of Healin and Mental Hygiene "natural", or itema 23a or 28e-1 show mortant: if tiem 27 is marked other then "natural", or itema 23a or 28e-1 show any njury or other traumatic event, the Maulcal Examinar must be notified at onc.		21. Signature of Funeral Service	Ma	sey		7922 Wise	Ave.	al Home of Dundalk,	Maryla	alk, I and 2	inc. 1222
			23a. Part1. Enfor the disease, or shock, or heart failure. List	complications that only one cause or	t caused the	leath. Do not ent	er the mode of dying	g, such as car	diac or respiratory arr	est,		Approximate Interval Between
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0		Jer	Sequentially list conditions, if any, leading to immediate	b. — Due t	o (or as a con		W 10-7 1	<i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> - <i>y</i> -				7
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XOD	w requires thet the death certifi been signed by the ettending should be deteched for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pre		T			23d.	Date of delive	эгу
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🔼 No		e birth 2 □ F gnant at time known		Ectopic pregnancy Other (specify)				Month	Day Year
٦ 5	het the		9 ☐ Unknown* Part II. Other significant condition	1		resulting in the un	adorhina cauca auca	n in Port I	23o Did tol	22222 1122 2	ootobuto to th	ne cause of death?
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DIVISION	Atten r deatl sctor; y the	flca	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be 28e. Pla	ce of Injury - A	At home, farm, stre		63 2 110	28f. Location (St	reet and Nu	mber or Rura	l Route Number.
5	s after or ni Dire	Certification:	4 ☐ Homicide determ	bui	lding, etc. (Sp	ecify)			City or Towr	, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after defector. After this certificate has I to the Funeral Director. After this certificate has I completely filled in by the funeral director, page 2 s	edical	29a. Certifier 1 ★ Certifyin (Check only one)	Examiner: On the	he best of my basis of exam anner stated.	knowledge, death nination and/or inv	occurred at the time restigation, in my op	e, date and pl inion, death o	lace, and due to the ca occurred at the time, da	tuse(s) and ate and place	manner as st	ated. the cause(s)
	To tl withi To tl comp	Ž	29b. Signature and title of certifier	11			29c. License	number	2	9d. Date sig	ned (Month)	Day, Year)
			1600	al	-12)		32106		May	8, 2	2008
	6		30. Name and address of person	who completed ca	use of death (Item 23a) (Type, I	Print) Union I	Memoria	al Hospita	1 /	, .	01010
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Si	gnature No:	rth Calve	rt St.	Baltimore	, Mary	/Land	21218
	Registr		MAY 1 9 200	50	D. 1	Coarle	9					

06-03078 Carol Ballinger Loy

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 15829

		1- For State Registrar		Cer	tificate of	Death			R	eg. No.		
Physicia	an/	Decedent's Name (First, Middle,t)	.ast)	-					Date of Dea Month		,]	3. Time of Death
dical Exami	ner	Carol Ballenge	•						May 7, 20	06		0530 hrs
		4a. Facility Name (if not institution, Route 270 South Bound				Ib. City, Town Urbana	or Location	of Death		4c. County		
Funeral			Sex 7. Age		ast birthday)	If Under 1 \	Year If Und	ler 24Hrs s Min.	_	rth (MM/DD/YYYY	Foreign	
Director			M 2XF	61	Yrs.		Days Hour	5 IVIIII.	Jan. 3	30, 1945	Cou	untryEngland
any		Usual Residence of Decedent 10a. State 10b. County	ī	10c City	Town or Locati	on						10d Inside City Limits
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Maryland 28a-f show d at once.	턍	10e. Street and Number	ICK	110	Jeffek	10f. Zip Cod	e			Og. Citizen of Wh	nat Coun	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hyggene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Dire	Maryland Freder 10e. Street and Number 5405 Stone Road				21703				U.S.A.		,
th wit	Funeral	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent I Armed Forces?	Ever in U.		s Decedent of es, specify Cu			ecify Yes or No Rican, etc.)	14. Race White		can Indian, Black,
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OO; J with grene ther t	ē	17. Father's Name (First, Middle, La					18 Mothe	r's Name	(First Middle	Maiden Surname		T
215-0036 be filed within 7 ntal Hygiene ked other than ent, the Medica	B	Floyd Ballenge	-						Hall		,	
21 ould b d Men s mar	리	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (S				mber, City or Tow	n, State,	Zip Code)
MD and 2 sho alth and 2 is m 27 is		Kathryn W. Loy	(Daughter)	_			_	Winc		VA 2260		
ore, ss l an of Hea If ite		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		Place of Disposi crematory or oth		cemetery,		Date	20c. Location -	City or	Town, State
Page ment or otl		4 Omation 5 Other Spec		Mt	. Hebro			1 .	0/06	Wincl	nest	er, VA
Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature of Funeral Service Li	tensee		22. N	ame and Addr	ess of Facilit ineral	Hom	e			22601
Physician	-	23a Part I. Enter the disease, or co		the death.	Do not enter th	28. S. ne mode of dyi	Pleas ng, such as d	ant cardiac o	Valley r respiratory arr	Rd., Will est, shock, or her	iche:	ster, VA
/Medical		failure List only one cause or Immediate Cause (Final disease	each line. a. Multiple Injuries									Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a conse	quence of	f):							
	ř	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	dience of	F)·							
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	c									
ecuted and transit		events resulting in death) Last	Due to (or as a conse	quence of	f):							
760, cate be evec physician a	n/Medical	UNPENDED	AMENDED									
8760, tificate be ng physic as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	-		tal death	2 Destant	0.050.00		23d. Date of		
Box 68 e death certif the attending ed for use as	sicia	past 12 months?	4 Pregnant at		ath	ner (Specify)	5ccopi	ic pregna	пісу	Month	D.	ay Year
Bo ne deal the al	Phys	1 Yes 2 No 9 Unkno	9 Unknown									
ires that th signed by lbe detach	by P	Part II. Other significant condition	is contributing to death	but not re	esulting in the u	nderlying caus	se given in Pa	art I.				he cause of death?
rds, Frequires									24a. Was			opsy findings available
of Vital Records, R Physician: The law require After this certificate has been si neral director, page 2 should b	Completed								autop	osy p		ompletion of cause of
tal Rec cian: The certificate ector, page	Con								1 Yes		✓ Yes	s 2 No
ician: s certi	Be	25. Was case referred to medical examiner?	Hospital:		500 4 2524	r	Other,					
of Villing Phys After this funeral di	. To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injur	rv	ER/Outpatient 28b. Time of Ir		njury at Worl			Residence 6 w		Scene
on c anding ath or: Af	Certification:	1 Natural 5 Pendin	g May 7, 2006	ear)	0514 hrs		Yes 2	2		auto collision		
Division tal or Attendin rs after death al Director: A	fica	2 Accident Investig	28e Place of Ini	ury - At ho	ome, farm, stree	et, factory, offic	ce building, e	tc.			er or Rur	al Route Number, City
Division Hospital or Attence 24 hours after death Funeral Director: stely filled in by the	erti	4 Homicide determ		or Road	d / Highway				or Town, S Rte. 270, S/	State) /B 26 mile ma	arker, l	Jrbana,
Division of Vital Records, P.O. Box 68760, To the Hospital or Atending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.			sician: To the best of my ner:On the basis of exan									
To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.	miation a	- Indiana investigat		ense number		t trie time, date			
~	~	11 1.1.	(11.0				C.M.E.			29d. Date signe May 7, 200		ui, Day, rearj
7		30. Name and address of person w	no completed cause of d	eath (Item	23a)					1, 1, 200		
12			sistant Medical Exa	,	_111 Penn	Street, Ba	ltimore, M	1D 212	01			
	tate	01.0	32. Registral		A 40 .							
Regis		1511.21 T A TOOO	Jackson 10									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔠 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month LEACH **Physician** MAE 0155 M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center NIA Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth Month, Gay, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212-30-5032 Usuel Residence of Decedent 1 M 2 F Director with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location , or itama 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at Baltimore 1 Nes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: if tiam 27 is marked other than "--- any injury or other traumeth." 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ 3 □ Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Yrs 17. Father's Name (First, Middle Dast) hea 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street an 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Si naly e of Fun a Service of nse Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HypoxIa **Physician** 30 minutes /Medical Due to (or as a consequence of) Examiner Myocardial Infarction 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical Examiner be detached for use as the burial-transit Renal transplant 5 years or Attending Physician: The law requires that the death certiticate be executed Status post that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, End Stage Renal Disease IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Mellitus Diabetes 1 Yes 2 No 3 Probably 4 Unknown Peripheral Vascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funaral Director: A completely filled in by the ft. 1 Yes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) Signature and P19812 30. Name and aldress of person who completed cause of death (Item 23a) (Type) Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9 2006

1- For Amend #8 Per FIF take of Maryland Department of Health and Mental Hygiene 2006 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Roberta Molinaro 5:00 AM Physician May 11,2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 2907 Sarasota Court Ellicott City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗗 F 70 210 26 1935 Yrs. 12/14/1935 Director PA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show Item 27 is marked other than "naturs!; or Items 23a or 28e-f above other traumatic event, it a Maxical Examinar Trust be natified at 1 Yes 2 No MD Director Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 2907 Sarasota Court 21042 USA Funerai 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nit. Pages 1 and 2 should be filed within entment of Health and Mental Hygiene. ortent: If Item 27 is marked other then injury or other traumatic event, Item. Teacher health & Physical 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nicholas Gianni Estelle Kisnoski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Nicholas Molinaro / Son 2907 Sarasota Ct, Ellicott City MD 21042 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or once. CAthedral Cem May 16, 2006 Scranton PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (orlas a consequence of): lar /Medical Examiner Sequentially list conditions, it any, loading to immissible cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of): Examiner requires that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4 Pregnant af time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2,2 No 1 Yes 2 No certificate 1 Yes Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death . Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature an Mittle of certifier 29c. License number inaur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Dr. Susan Noliano, 1234 Doctors Way, Ellicott City MD 21042 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 1 9 2006 Registra

			1 - For State Registrar	State of Ma	aryland /	-	irtment o tificate			-	giene Reg. No. 2	006	15832
F	Physici /Medic		1. Decedent's Name (First, Middle, Las Tatiana Michal							2. Date of Dea Month May 13	Day	Year	3. Time of Death 2:05am м
) 	Examin		4a. Facility Name (If not institution, give Shady Grove Adver	ntist Hosp			Rock	wn, or Location				nty of Death	
	uneral rector		5. Social Security Number 6. Security Number 1033 24 3774 11	7. Age	84	Yrs.	If Under 1 Months C	ear If Und	der 24 Hrs. 's Min.	8. Date of Birt (Month, Dat 1/1/	h y, Ye <i>ar)</i> 1922	9. Birth Cou	place (State or Foreign intry) Ukraine
5-0036 72 hours after death with the Maryland	or 28a-f ehow	Funeral Director	10a. State 10b. County	gomery d Lane	10c. City, To	own or Lo		erson	208		10g. Citizen	of What Cou	•
5-0036 72 hours after death	od other then "naturel", or items 23e or 28e-1 ehow event, the Medical Examinar must be exhitted at	by	11. Marital Status 1 Never Married 2 Married **Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 DN If Yes, Give Year or Dates:			Vas Deceden Yes, specify		Origin? (Spe can, Puerto	ecify Yes or No- Rican, etc.)	14. F E Spe	USA Race - Ameri Black, White, cify:	ican Indian,
d d d d	her then "natur it, the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5		(Give : life. [ent's Usual C kind of work o OO NOT use i	lone during n etired)			Com	Business/Ir	
Mer de		To Be	17. Father's Name (First, Middle, Last) Sergie Kornus						Maria	e (First, Middle, Hlusch	hshenk	0	
	item 27 is marke other traumatic		Oleg Michalowsky			2392	4 Barl	ey Fie	ld Lar	ne, Dic	kerson	MD 20	842
S S	Important: If ite eny injury or ot once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑ 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens)	1	t Hi	sition (Name natory or othe 11s Ce	m.	 Mav 1	19, 2000	20c. Locatio	on. MA	
De de de	F F G		23a Part I Enter the disease of comm	lications that caused	the death D		1201	East	Fort A	ens Fun Ave Bal	timore	ome In MD 2	nc. 1230 Approximate
/Mo Exa	sician edical miner	Examiner	23a. Part1. Enter the disease of comp shock, or heart failubs. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, hay, eating to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c.	a consequence	e of):	ance			, isopilatory a			Interval Between Onset and Death 2 years
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. 0	oy the ached	Physician/M	in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregi Other (speci					Month	Day Year
- ĉ	been signed I should be det	þ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the un	derlying caus	e given in Pa	rt I.		obacco use co ′es 2 □ No		he cause of death?
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		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatier	nt 2□ ER/0	Dutnation	3□ DOA	04		ne 5 ☐ Resid		Dub (D)	
⊏ 2"	fter th	ation: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 28b	Time of Injury		Injury at Work?	2	28d. Describe h			<i>y)</i>
DIVIS tal or Atter rs after de	To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	iry - At home, c. (Specify)	farm, stre	et, factory, o	fice	4	28f. Location (S City or Tow	itreet and Nui n, State)	mber or Rura	al Route Number,
i hs Hospi in 24 hour	the Funer pletely fill	Medicai	29a. Certifier (Check only one) Certifying Phylogenesis (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examination a	and/or inv	estigation, in	my opinion, o	leath occurre	ed at the time, o	date and place	e, and due to	the cause(s)
To with	COU	2	29b. Signature and title of certifier				29c. L	cense numbe	er	2	29d. Date sign	ned (Month,	Day, Year)
į	2		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type, f	Print)	10622	34	0	May	15,2	006
	10		MANISA ALGAL	val 9-	207 1	neou	OfC	Enler.	Dr. 1	axon	lem	00	0450
. Y	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2006	ompleted cause of de	irs Signature	rede	,						

Mathias, Zelma 0=114/06 1510 68760, Baltimore, Maryland 21215-0036

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			For State Registrar	State of Ma	iryland				ealth and r Death		Reg. No.	2006	5 15	833
	Physicis	20	1. Decedent's Name (First, Middle, Las							2. Date of De Month	Day			of Death
	Physicia /Medic	al		ATHIAS						MAY 14) P M
1	Examin	er	4a. Facility Name (If not institution, give						Location of Death			County of De		
			SUBURBAN HOSPITAL 5. Social Security Number 6. Se		(In yrs. lasi	t hirthday)		THESI)A If Under 24 Hrs.	8 Date of Bir		ONTGOM		or Foreign
	Funeral Director		147-44-2729	M 282F	99	Yrs.	Months		Hours Min.	8. Date of Bir (Month, Da May 19	y, Year) 190	6 MI	rthplace (State Country)	
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside	City Limits
	Aaryli f sho	5	MD Montgom	o rw	Che	vy Cl	hase						1 [X] Ye	s 2 No
	28a-	Director	MD MOTEGOTE 10e. Street and Number	ELY	One			p Code			10g. Citiz	en of What C	Country?	
	3a or		8100 Connecticu	it Avenue	Apt i	#222	20	1815			ī	ISA		
	death rs 2:	Funeral	11. Marital Status	12. Was Decedent I		13.			spanic Origin? (S) n, Mexican, Puerto	pecify Yes or No		4. Race - Am	erican Indian,	
36	72 hours after death with the Maryland natural', or iteme 23e or 28e-f show diesi Esamblers, aust be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	i	ir Yes, spa 1 ☐ Yes		Specify:	rican, e(c.)		Black, Wh Specify:	White	
ğ	2 hou	ted	15. Decedent's Ed			16a. Deced	dent's Us	al Occupa	ation	kina	16b. Kir	nd of Busines	s/Industry	
21215-0036	C _ 9	Completed	(Specify only highest gra	College (1-4or 5	+)				furing most of wor.)	(III)				
	filed withi Hygiene. other then	Con	12			Но	mema	ker				wn Hom	e	
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nam					
yla	should be and Mental I marked o	၉	Soloman Pollack							la Otter			T 0 11	
lar	2 sho		19a. Informant's Name/Relationship (7	Гуре, Print)			00.8		and Number or Ru				Zip Code)	13
	1 and 2 Health tem 27		Edward Mathias/S 20a. Method of Disposition	on					NW, Wash	nington, Date			or Town, State	
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐			e of Disponetery, crer	-		1	0.06				
ţ	rtmer rtent rjury		4 □ Donation 5 □ Other (Specify 21. Sign were of Funeral Service Liger		Bet	hel l	Memor	ria⊥	Park $5-1$ is of Facility 1 :	9-06 ngleshy	Penr.	sauker ns. Tr	ı, NJ	
Ba	permit. Page Department of Importent: If any injury or ance.		I Lenna Ve	llow			2426	Cove	Road, P	ennsauk	en, N			U
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each li	the death.	Do not ent	ter the mo	de of dyin	g, such as cardiac	or respiratory a	rrest,		Approxim Interval B Onset an	etween
	Physician		Immediate Cause (Final disease or condition	a by	ady	ca	rd	101					Onset an	J Death
	/Medical		resulting in death)	Due to (or as	a conseque	nce of):	•			, , , , , , , , , , , , , , , , , , , ,				Of Contract of Con
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68760,	ificate be executed g physician and as the burial-transit	al E		300 10 (0. 00										
387	phys phys	edicat		. d										
		/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of d	elivery	
Вох	death atter	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant at			⊒Ectopic ⊒ Other (s	pregnancy pecify)				Month	Day	Year
P.O.	the c sy the achec	hysi	9 Unknown	9□ Unknown										
	 requires that the death cer been signed by the attendir should be detached for use 	by PI	Part II. Other significant conditions of	ontributing to death b	ut not resulti	ng in the u	nderlying	cause give	en in Part I.	23e. Did 1	obacco u	se contribute	to the cause o	death?
ğ	quire an sig uld b	edit								10	Yes 2[□No 3□F	Probably 4	Unknown
of Vital Records,	aw re s bee 2 sho	Completed								24a. Was		24b. Were	autopsy finding completion of	s available
æ	The I	E								perfo	2 No	death	s 2 No	cause or
ita	ian: rtifica stor, p	Bec	25. Was case referred to medical						26. Place of Dea		/ \			
f	Physician: r this certific ral director,	၉	examiner? 1 ☐ Yes 2 No	Hospital: 1 Nnpatie	ont 2 EF	VOutpatier	nt 3 🗆 🗅	OA Oth	er: 4 🗆 Nursing H	ome 5□Resi	dence 6	Other (Sp	ecify)	
	ng Pt fter tt neral	ü	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year) 2:	8b. Time o Injury	of	28c. Injun Worl	at </td <td>28d. Describe</td> <td>how injur</td> <td>occurred</td> <td></td> <td></td>	28d. Describe	how injur	occurred		
Sio	Attanding r death.	ati	2 ☐ Accident investigation	1			М	10	Yes 2 No					
Division	or Att	ŧ	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At hom c. <i>(Specify)</i>	e, farm, st	reet, facto	ry, office		28f. Location (City or To			Ru <i>ral R</i> oute Nu	imber,
	urs al	Ce				-4		4 - 1 - 1	- 4-4					
	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funersi Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification;		ysician: To the best niner: On the basis o and manner st	f examinatio									ı(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner St			2	9c. Licens	e number		29d. Dat	e signed (Mai	nth, Day, Year))
	5 ₹ ₹ 8		Manne	3440				NI	20 all	9	6	5/11	06	
	1		30. Name and address of person who	completed cause of c	leath (Item 3	3a) (Tyne	Print)	0	y L	1		, T	J. 4.	
	e		NO tri Clara	Ha a a				orget	own Rd.,	Bethes	da, I	MD 208	14	
		ate	31. Data filed (Month, Day, Year)	32. Regist	ar's Signatu	and I								
	Regist	rar	military of motor	THE RESIDENCE OF THE PARTY OF T										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5 PER FH C856 6/8/06 WS State of Maryland / Department of Health and Mental Hygiene 11 11 15 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6.20P M MECHLINSK 2006 Mai 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Ellicott City Health & Rehab Center Ellicott City Howard 5250cial Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) 02/17/1906 Birthplace (State or Foreign
Country) 1□M 2**X**F Months Days Hours Min Yrs. 100 Maryland Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits N/A 1XYes 2 □ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 1425 Stonewood Road 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ludwig Szczesniak Helen Draszkiewicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5462 Marlin Street Rockville, Maryland 20853 Natalie Schoeberlein 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State competery, crematory or other place)
Holy Rosary Cemetery 05/20/2006
Baltimore 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Carderas Cular Defice Alberosclerotic Due to (or as a consequence of): Bacterial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØÛnknown

Physician /Medical Examiner

Physician

/Medical

Director

Completed by Funeral

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item 27 is marked other than "neturel", or items 23e or 28a-f show other treumatic event, the McCical Examinat must be mutified at

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Mental

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Pages 1 and 2 should be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Be Completed by Physician/Medical

burial-transit and physician the as use ned by the atten detached for u should be page 2 s has certificate funeral director After after death. the

Certification: To

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Physicien: The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760,

IF FEMALE:	
23b. Was decedent prec	nant
in the past 12 mont	
1 ☐ Yes 2 🔀 No	

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No

25. Was case referred to medical examiner 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 🗀 Suicide

29a Certifier

4 Homicide

5 Pending

6 Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) investigation

and manner stated

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certifier

29c. License number D30641

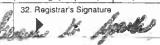
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) May 16

30. Name and address of person who completed cause of death (Item 23a) (Typen Print)

(Type-Print) Kell New Wade Road Baltimus May land 21291 105 Sabapulh 201-Kamesh

31. Date filed (Month, Day, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) May 16, 2006 Year Month 1515 **Physician Betty Elizabeth Miller** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore Washington Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 25, 1937 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🗓 F 148-32-4422 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Baltimore Anne Arundel Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or U.S.A. 21061 7341 Green Acre Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. important: if fam 27 is marked other than "na eny injury or other treumatic aux." Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma M. Pettigen Silas W. Robinson Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7341 Green Acres Drive Glen Burnie, Maryland 21060 Warren Miller Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Brooklyn Park, Md. 05/23/06 Cedar Hill Cemetery & Mausoleum 4 Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Caused final disease or condition resulting in death) Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death **Physician** /Medical Examiner Section tilly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner buriel-transit or Attending Physician: The law requires that the death certificate be executed physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the ettending f IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 ☐ Probably 4 ☑ Snknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 2 🗆 No 1 ☐ Yes 22 No After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 V R/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Alatural 5 Pending 1 Yes 2 No within 24 hours efter death. To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital 23s Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 26 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier Deputy and address of person who completed cause of death (Item 23a) (Type, Print) 1995 America nes, mi 31. Date filed (Month, Day, Year) MAY 1 32. Registrar's Signature State 9 2006 Registrar

				For State	State of M	•	,		ealth and M	lental Hyg	iene	3 1200	15000
				Registrar 1. Decedent's Name (First, Middle, Last)	1		Certificate	e or L	Jeath	2. Date of Dear	eg. No.	UO.	3. Time of Death
	÷.	Physicia	an			Miller				Month	Day	Year	10:38 A M
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		Examin	er ن	Upper Chesapeake M				el A			Har	ford	
		Funeral		5. Social Security Number 6. Sec	7. A	ge (In yrs. last birt	nday) If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	9. Birthp	lace (State or Foreign
	100	Director		214-03-9869]M 2(X)F	90	rs.	Days	TIOU.S IVIII.	May 18,			yland
		and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	Od. Inside City Limits
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5	36	or It	by Fu	1 Never Married 2 Married	1 Tyes 2 If Yes, Give	_	1 ☐ Yes 2		Specify:		Speci	y: Whi	te
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9	6,	of Health of Health litem 27 I		20a. Method of Disposition	Daugirte		Disposition (Nam				20c. Location		•
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lordelia Virginia Miller M8			edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes	of examination and	death occurred a	at the tim , in my or	ne, date and place, pinion, death occurr	and due to the cred at the time, d	ause(s) and m ate and place,	anner as si and due to	ated. the cause(s)
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	(2		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type, Print)	Cal	06322 2GE 15	CKARN	5		
		0		SOMPPER CH	SAVEAU	E Dr.	BECH	E,	NP	9/4			
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Registrar

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			. For	State of Marylan	d / Department of Health and	Mental Hygier	ne	
			State Registrar		Certificate of Death	Reg. I	No. 2006	1583
	Physicia		1. Decedent's Name (First, Middle, La. Charlotte	A. Mela	anson	2. Date of Death Month	200 Year	3. Time of Death Of: 10 PM
	/Medic Examin Funeral Director		4a. Facility Name, (If not institution, gives the second of the second o	15 Nursing	4b. City, Town, or Location of Death ast birthday) If Under 1 Year If Under 24 Hrs Wonths Days Hours Min.	8. Date of Birth	4c. County of Death 9. Birthpl County APPLICATION	1 Me YC lace (State or Foreign try)
D &	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiane. If of Health and Mental Hygiane. Instural; or itams 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E. (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last,	12. Was Decedent Ever in U. Amed Forces? 1	If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done) If Yes, specify Cuban, Mexican, Puerl 16a. Decedent's Usual Occupation (Give kind of work done during most of work done)	specify Yes or No- to Rican, etc.)	Citizen of What Count 14. Race - America Black, White, e Specify: Wh Kind of Business/Ind	an Indian, atc.
10	permit. Pages 1 and 2 should be filed within Department of Health and Mehatal Hygiane. Important: if item 27 is marked other than eny injury or other traumatic event, it a Megance.	То	19a Informan me/Relationship (20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification of the control of the contro	Removal from State	19b. Mailing Address (Street and Number or Richard of Disposition (Name of Jemetery, crematory or other place) 22. Name and Address of Facility Cremans	Date 200. 4-06 FO Alternat	Location - City or for Drest Hi Tives Fun	mp wn, State
	cate be executed WMA physicien and the burial-transit the burial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially 1st conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	sedir	Dresus	Interval Between Onset and Death
.O. Box 6	ires that the death certific signed by the attending p d be detached for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	I death 3 Ectopic pregnancy		23d. Date of deliver Month	ry Day Year
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io S	Hospital or 14 hours afte Funaral Dir tely filled in t		29a. Certifier Certifying P	sicien: To the best of my kno	wledge, death occurred at the time, date and place	, and due to the cause	(s) and manner as sta	ated.
,	To the He within 24 To the Fu	Medical	29b. Signature and title of certifier	and manner stated.	tion and/or investigation, in my opinion, death occurrence and the second secon	29d. (Date signed (Month, C	
			30. Name and address of person who	HUNA MIN	n 23a) (Type, Print) , 2300 DULANEY VA	LLEY BOAL	TIMON	1047 MD
	Sta Registr		31. Date filed (Month, Day, Year) MAY 1 9 2006	32. Registrar's Signa	huro Live Lis	No.		5

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Mathews **Physician** Month Year Clara 21:16 M 06 05 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 217-24-9588 July 8, 1930 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 21 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Glenwood Street #709 20701 death USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housekeeping none Johns Hopkins Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Patterson Lavinia Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 924 Tide Mark Ct. Virginia Beach, VA 23464 Diane Jackson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If ite any njury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 🗷Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signatura of Funeral Service Ronald nan 23a. Part1. Enter the disease, or complications that caused the shock, or hear failure. List only one cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Klebsiella **Physician** pneumonia sepsis days disease or condition resulting in death) /Medical Examiner weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗙 No sate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Xinpatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mmer MD D0059173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kemmer 31. Date filed (Month, Day, Year) MAY 1 9 2006 32. Signature Registrar

NAME KNOWN TO PHYSICIAN: MAXEY-BERRY, KAREN Baltimore, Maryland 21215-0036

		Pleas 1 - Sor State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of			ene . No.? () () ()	1584
Physic /Medi		Decedent's Name (First, Middle, Karen Maxey-Bei	•		ramouto or		2. Date of Death Month MAY	Day Year 10, 2006	3. Time of Death
Examination Funeral Director		4a. Facility Name (If not institution, VA MARYLAND HEA 5. Social Security Number 214-72-0799	LTH CARE SY 3. Sex 1 M 2 N F	STEM e (In yrs. last birthday) 47 Yrs.	4b. City, Town, of PERRY If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y.	ear) Co	nplace (State or Fore untry)
	tor	Usual Residence of Decedent 10a. State 10b. County MD Harf		10c. City, Town or Lo			an 20, 1	737 Mai	yland 10d. Inside City Lim 1 □ Yes 2x͡S
s 23a or 28a nat be noti	rai Director	10e. Street and Number P. O. Box 237			10f. Zip Code 21160			Citizen of What Co	
netural', or items 23a or 28a-f show dical Exardi or must be notified at	d by Funerai	11. Marital Status 1 Never Married 2 A Marrie 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	*82 - 91	If Yes, specify Cub 1☐ Yes 2☒ No		lican, etc.)	Black, White Specify: Wh	ite
then the Me	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occup kind of work done DO NOT use retire alegal	during most of workin	g 16	b. Kind of Business/	industry un
ind Mental Hygir s marked other umatic event,	To Be C	17. Father's Name (First, Middle, L. Stephen DeVenny	7			18. Mother's Name Barbara G	ertrude l	Robinette	
Health and em 27 is m ther treum		19a. Informant's Name/Relationshi Manuel Holmes, 20a. Method of Disposition	Jr./husband	4432 20b. Place of Dispo	Conowing		ngton, M		
Department of Importent: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signal No. 1) Fineral S	echy)	tor s	2. Name and Addre	ess of Facility tomy Board	655 W. I	Baltimore	Street
nysician Medical		23a. Part1. Enter the disease, of cashock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each li	the death. Do not en	iter the mode of dyl	, MD 21201 ng, such as cardiac or	respiratory arrest	,	Approximate Interval Betweer Onset and Deat UNKNOWN
ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Each of John and Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):					
ate has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant	d.		⊐Ectopic pregnanc			23d. Date of deli	very
ed by the atte	hysicia	in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	4☐ Pregnant at		Other (specify)	у		Month	Day Year
been signed should be de	b	Part II. Other significant condition	ns contributing to death b	out not resulting in the u	underlying cause gr	ven in Part I.		2 No 3 Pro	
	Completed							d? prior to death?	topsy findings avail completion of cause 2 No
After this funeral di	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending investigations.		ury 28b. Time o	of 28c. Inju			ce 6 □Other (Specinjury occurred	rify)
recto by th	Certification;	3 Suicide 6 Could no 4 Homicide determin	ned 289. Place of in building, et	jury - At home, farm, st ic. (Specify)			City or Town, S		
res after rel Dire		29a. Certifier 1 Certifying	Physician: To the best			ime, date and place, a opinion, death occurre			
within 24 hours after death To the Funeral Director: completely filled in by the	Medicai		and manner st	ated	29c. Licens	se number	29d	. Date signed (Month	n, Day, Year)

			1 - For Stete Registrar	State of Ma		artment of H		R	eg. No.	06 15841
	Physici		1. Decedent's Name (First, Middle, La BURNIS	ist)	PARK	ER		2. Date of Dea Month		Year 3. Time of Death Year
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)	/ //		Location of Death	777-9	4c. County o	
			5. Social Security Number 6.	Sex 7. Age	OSPITAL (In yrs. last birthday	15 of 14 of	MONE If Under 24 Hrs.	8 Date of Birth		N/A Righthalago (State or Foreign
	Funeral Director			1 ∑ M 2 □ F	59 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Aug 16,	Year) 1946	Birthplace (State or Foreign Country) Maryland
	pur *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryis -f sho	tor		Arundel	7.		n Burnie			1 Yes 2 □ No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	
	s 23a	ral	112 Henson Road	12. Was Decedent Ex	vor in II C 12	Mas Dandon of H	21060	anifu Van av Na		U.S.A. - American Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic evant, The Medical Endriff at must be multified at once.	by Fune	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗶 No	Specify:	Rican, etc.)		, White, etc.
9	2 hou	ted t	15. Decedent's E	ducation	16a. Dece	edent's Usual Occupa	ation	·	16b. Kind of Bus	iness/Industry
21215-0036	vithin 7 ne. han "r	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retired	Teacher	ing	Anne Arur	ndel County Public
d 21	filed w Hygiel other tl	CO	17. Father's Name (First, Middle, Las	<u>4</u>		361100	18. Mother's Name	e (First, Middle, i	Maiden Sumame)
/lan	should be and Mental s marked c	To Be	Ernes	t Parker				Anr	nie Parker	
Maryland	12 sho h and I risma		19a. Informant's Name/Relationship Johnnettia Parker Wife		1	ing Address <i>(Street a</i>			•	tate, Zip Code)
ē,	s 1 and 2 Health Itam 27 othar tra		20a. Method of Disposition		20b. Place of Disp		!			City or Town, State
<u>E</u>	Pages nent of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special			ted Methodist	1. 1.	05/20/06	Glen Bu	ırnie, Maryland
Baltimore,	permit. Departr Importa any inji		21. Sign tue of Funeral Service Line	1. Ester	SP 2	2. Name and Addres Estep Br	ss of Facility others Funer taw Place Ba	al Service, F	P. A. 21217	
ľ			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause to one cause on each line	he death. Do not er					Approximate Interval Between
	Fnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Interst	titial Lu	ng Disea	se			Onset and Death 4 year 5
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9	ertifica ling ph	Med	IF FEMALE:	02- 16		-0.00				
Вох	leath certific attending pi for use as f	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mont	
<u>О</u> .	res that the de signed by the a be detached f	hys	9 🗆 Unknown	9□ Unknown						
ecords, I	= 0 0	by	Part II. Other significant conditions	contributing to death but	not resulting in the t	underlying cause give	en in Part I.			oute to the cause of death?
eco	e law requ has been je 2 shouli	Completed						24a. Was a autops	iy pri	ere autopsy findings available or to completion of cause of
<u>a</u>	Physician: The this certificate hare al director, page	e Cor	OF Man ages referred to modical						2 No 1	ath? ☑Yes 2☐No
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n of	Attending Physician: r death. actor: After this certifica by the funeral director, I		27. Mannar of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (Worl	at </td <td></td> <td>ow injury occurred</td> <td></td>		ow injury occurred	
Division	Attending at death. actor: Atter by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not	be Osa Blace of Injur	y - At home, farm, st		Yes 2 No	28f. Location (St	reet and Number	or Rural Route Number,
<u>≥</u>	s after s after al Dira	Certi	4 Homicide determined	building, etc.	(Specify)			City or Town		
	To the Hospital or Attent within 24 hours after deatl To the Funaral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	Physicien: To the best of eminer: On the basis of eand manner state	examination and/or in	th occurred at the time the time of time of time of the time of time o	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and mani ate and place, an	ner as stated. d due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number			(Month, Day, Year)
1	0		1784	END.		RES-C	000		may, 17, 2	2006
0	1		30. Name and address of person who sept Stephens, InD				Maryland	21287		
	Sta	21	31. Date filed (Month, Day, Year)	32. Registrar 2008	's Signature	,				
	Registr	ar	MAY 1 9	2008	and It I	Cosses				

			State of N Registrar	Maryland / Dep	partment of F		Mental Hygie	11 12 12 10	15842
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) OROTHY A. Facility Name (If not institution, give street and number)	r)	PG 4b. City, Town, o	r Location of Death	2. Date of Death Month MAY	Day Year 16 200 4c. County of Deat	~
	Funeral Director		5. Social Security Number 6. Sex 7. 7. 217 - 28 - 0238 1 M 2 F	Age (In yrs. last birthda) 72 Yrs.	400	If Under 24 Hrs. Hours Min.	8. Date of Birth Apr 21, 1	n/ 9. Bin 1934 Wes	a hplace (State or Foreign untry Virginia
	e Maryland 8a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md • n/a	10c. City, Town or Balti	more				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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920	within 72 hours efter death with the Maryland ene. then "neturel", or items 23a or 28a-f show hs Mudical Examéra: must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Deceder Armed Force 1 Yes 2 If Yes, Give 4 Year or Date:	No	B. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
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Maryland 2	should be filed nd Mental Hygid marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) James Paul Martin, S	Sr.		18. Mother's Nar Edith	re (First, Middle, Mai Keafel	iden Sumame)	
Baltimore, Mary	es 1 and 2 of Health a f item 27 ls r other tra		19a. Informant's Name/Relationship (Type, Print) Melvin T. Petty, Jr./s 20a. Method of Disposition 1 □ Burial 2 ত Cremation 3 □ Removal from Sta 3 □ Other (Specify)	SON 149 20b. Place of Dis		on Aven		-	d . 21224 Town, State
Balti	permit. Pages. Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service Ligensee				zorowski e. Balti		1 Home, PA d.21222
68760,	cate be executed // Medical Examiner and physicien and phy	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		FAILU	IRE			Approximate Interval Batween Onset and Death 14 Hours
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)	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier ALEA DIALLO M	EDICA D	29c Licens			Date signed (Mont	
1	3		30. Name and address of person who completed cause of Alfa Diallo in the Jo		e, Print)	pital, 6	00 Noveres	Wolfe S	2006 Bullimore Freet VIO 2121
	Sta . Regist		31. Date filed (Month, Day, Year) MAY 1 9 2006	strar's Signature	ins Hos	y			

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of or			iene	0116	158	3
	Physici	an	Decedent's Name (First, Middle Page 1	, Last)				2. Date of Deat Month	th Day	Year	3. Time of Death	<u> </u>
	/Medic		Louis T	KEQUAR	D JR			MAY	16,	2006	10:05 P	M
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	Funeral Director		5. Social Security Number 3:3-07-6080 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last birthday, Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		9. Birthp Coul	place (State or Forei	<u> </u>
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23s or 28s-1 ahow other traumatic avant. the Medical Examinational Es	7	10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limit	
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9	or Ite	F	1 ☐ Never Married > Marr	Armed Forces?	0			Rican, etc.)		Black, White,	etc.	
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Maryland	Mental Mental arked c	To Be	LouisT	REDUARD			MARA		Derlt	_		
ary	should I	-	19a. Informant's Name/Relations		19b. Mail	ing Address (Stree	t and Number or Ru		City or To	wn, State, Zip	Code) 2183	
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0	the e	Physician/Med	1 Yes 2 No	4☐ Pregnant at t 9☐ Unknown	ime of death 5[Other (specify) _				MONTH	Day 19a1	
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	Jing P. After ti funera	on:	27. Manner of Death 1 XNaturat 5 ☐ Pendin	28a. Date of injury	/ 28b. Time o	of 28c. Inju	iry at ork?	28d. Describe ho	w injury occ	curred		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investig	not be]Yes 2 □No					
Division	or Al after of Direct in by	Certification:	4 Homicide determ		ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Str City or Town	eet and Nu , State)	mber or Rura	l Route Number.	
67	spital ours ours seral		29a. Certifier 12 Cartifyin	g Physician: To the best o	f my knowledne, deal	h occurred at the ti	me date and place	and due to the se				
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	(Check only 2 Madical one)	Examiner: On the basis of and manner state	examination and/or in	ivestigation, in my	opinion, death occur	red at the time, da	iuse(s) and ite and plac	manner as st e, and due to	ated. the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certific		M D	29c. Licen	se number	29	d. Date sig	ned (Month,	Day, Year)	
			1 Tunto	1 Fow	W(x)	D 24	4034		5/11	7/01	-	
-	(2)		30. Name and address of person	who completed cause of de	ath (Item 23a) (Type,				11	1100		
-	()		TIMOTHY LOW,	M.D., 7601	LOSLER	DRIVE TO	OWSON, M	ARYLAND	212	06		
	Sta		31. Date filed (Month, Day, Year)	69	r's Signature		•					
	Registi	ar	MAY 1 9 20	Ub Marker.	that's profession	hard .						

			State of Maryland / Depa 1- State of Maryland / Depa 25 per verb., G855	rtment of Health and M 5/19/06/96 bath	fental Hygier	
	प्रकृति । स्वाम	41	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Medic		Norma Ross		Month May 1.	2, 2006 12:10 AM
	Examir	ar and	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	a w K	31			804	WICOMICO
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birthplace (State or Foreign Country)
	Director		214-32-0203 73 Usual Residence of Decedent		Nov 13, 1	932 Maryland
	yland		10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	a-1st	tor	MD Wicomico Salisbury			1 ☐ Yes 21 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Exeminar must be notified at	rail	200 Civic Avenue	21801	USA	
	er de	Funerai	Armed Forces?	as Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
36	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 🖄 No If Yes, Give 1 3 ঐWidowed 4 □ Divorced Year or Dates:	☐ Yes 2K No Specify:		Specify: white
21215-0036	2 hou	ed	15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b	Kind of Business/Industry
215	hin 72	Completed	(Specify only highest grade completed) (Give kife. D Elementary/Secondary (0-12) College (1-4or 5+)	and of work done during most of work O NOT use retired)	ing	unk
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nd	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, II a Madical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)	unk 18. Mother's Name	e (First, Middle, Maid	en Sumame) unk
yla	should Ind Men	မ				
Baltimore, Maryland	12 short and 7 is m			Address (Street and Number or Run		
e, l	1 and Health em 27		Salisbury Nur. & Rehab Center 200 C: 20a. Method of Disposition 20b. Place of Dispos	ivic Avenue Salis		Location - City or Town, State
2	permit. Pages Department of h important: if ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	atory or other place)		and the state of t
ᆵ	artme ortan injury		4 □Donation 5 ②Other (Specify) in state 21. Secondary of Funeral Service Licensee 22.	Name and Address of Facility		
Ba	Depa impo any i		Romald S. Wade, hirector St	tate Anatomy Board altimore, MD 2120	d 655 W. B	altimore Street
М			23a. Part1. Enter the disease, or complications that caused the death. To not ente shook, or heart failure. List only one cause on each file.			Approximate
	Pnysician	g	Immediate Cause (Final disease or condition	1 Dia	20-	Interval Between Onset and Death
19	/Medical		resulting in death) a Due to (or s a consequence of):	1-00	D	Jean-
60	Examiner		Seminatially list applicance by Company	- Liont	Paclo	4100-
	p .≡	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1		
	and trans	Examiner	that initiated events	(2)		420-
8760,	cate be executed physicien and s the burial-transit		Due to (or as a consequence of):			
87	death certificate be executed e attending physicien and of for use as the burial-transit	dlcai	d	1000		
9 X	eath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atter after I for u	clar	in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day Year
o.	that the de ed by the detached	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
۵.	The law requires that the ste has been signed by th page 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Records,	w require been sig should b	ed b			1 ☐ Yes	2 1 → 10 3 Probably 4 Unknown
000	law re as bee 2 sho	Completed			24a. Was an	24b. Were autopsy findings available
Ä	The lav	mo;			autopsy performed' 1 Yes 2	
ita	ician: Th certificete ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
× ×	Physician: r this certific ral director,	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		me 5 Residence	6 ☐Other (Specify)
n c	ing P	inol	27. Manner Death 1 ** atural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred
isio	Attending r death. ector: After by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 Yes 2 No	OOf Location (Canada	
Division of Vital	after Direct Dir	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	City or Town, St.	and Number or Rural Route Number, ate)
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.	estigation, in my opinion, death occurr	ed at the time, date a	and place, and due to the cause(s)
	To the within 2. To the complet	ž	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Dey, Year)
			Allhein	0283	45	5/12/21
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	•		1 100
			WILLIAM ROBINS, M.D. 200 CIVIC AVE., S	SALISBURY, MD. 2	L804	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	. region		MAY 1 9 2006 Read to Branks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2006 Physician May 14 6:35pm Vivian Ann Rhodes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2/7 86 214-30-2977 Director May 16, 1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumetic event, the Madical Examination was the molified at 1 X Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 U.S.A. 918 Quantril Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2☐No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: If Yes, Give Year or Dates: Specify: þ 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene.
7 is marked other than "r filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Ridgley Emma Hungleford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If itam 27 is any injury or othar tra Brenda J. Hoben/Daughter 4504 Lyons Run Circle, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 05-18-06 Brooklyn, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc 21. Signature of Funeral Service Licenspe esallo 23a. Part. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6415 Belair Road, Baltimore, MD 21206 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardionyopathy Schemic years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 certificate be Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Vear Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ difficite Colitis wetashon c 1 Yes 2 No 3 Probably 4 Unknown Completed UNKNOWA primare 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 StNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attanding P 24 hours after death. a Funerel Director: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 15 2006 arlins 0 58303 6601 N.CHARLES STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON J. CHANCES, MS TOWSON MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 9 2006 Registrar

				Please	Type or Print in					•	
				1 _ State	State of Maryla				Mental Hy	7" 4 7" 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10016
				Registrar		Ce	rtificate c	of Death		Reg. No. UU	10040
	4.	Physic	ian	Decedent's Name (First, Middle, La.	st)				2. Date of De Month	eath Day Yea	3. Time of Death
		/Medi		Judy Faye	Sage				May	17 2006	
	Ray N	Examir	ner	4a. Facility Name (If not institution, give				m, or Location of Death	h	4c. County of D	
-				Upper Chesapeak				Air		Harfo	rd
		Funeral		5. Social Security Number 6. S	ex ☐ M 2 K F 7. Age (In y	rs. last birthday)	If Under 1 Ye Months Da		(Month, Da	av Year)	Birthplace (State or Foreign Country)
	3.5	Director		212-40-5492 Usual Residence of Decedent	X	63 Yrs.			Jan. 2	1,1943 Ma	ryländ
		land land		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
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		the 28a	rec	10e. Street and Number	Jiu	Der Mr	10f. Zip Cod	de		10g. Citizen of What	Country?
>		3a or	ā	138 McCormick St	reet.		210			USA	
ρη		death ms 2:	Funeral Director	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No		merican Indian,
	ယ	after and and and and and and and and and and	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No				o Rican, etc.)		
3	93	ral', c	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 □ Yes 2 💢	No Specify:		Specify: W	nite
_	5-0	within 72 hours after death with the Maryland gne. then "natural", or tiems 23a or 28a-f show rs Modical Evertires must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dece	dent's Usual Oc	ccupation one during most of wor	rkina	16b. Kind of Busine	ss/Industry
3	2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	itired)			
	2	filed within Hygiene. other then ent, Ire M	S	12		Logis	tics Ma	nagement S	F	·	vernment
		d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
	<u>×</u>	2 should be filed w n and Mental Hygien is marked other ti raumatic event, III	P	Ernest Leslie	Epperley, S			Clara		Scarboroug	
9	Jar	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other then "natural", or liems 23s or 28s-f show or other traumatic event, tra Medical Examinar mark to notified at	V)	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Str	eet and Number or Ru	iral Route Numb	er, City or Town, State	a, Zip Code)
	2	and 2 lealth m 27 her tr		Randy Sago/Son	100	4047	Hears	School_Roa		sville, Ma	ryland 21232
1	9	f of F		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Inemoval nom State	b. Place of Dispo cemetery, crer			Date	20c. Location - City	
=	altimore, Maryland 21215-0036	Pa tmen tant:		4 Donation 5 Other (Specify	- 75	arford M			2/06	Aberdeen,	Maryland
10	Bal	permit. Pages 1 and 2 Department of Health a Important: if item 27 t. any injury or other tra ances.		21. Si nature et Funeral Service Licer	1 1	MC ²²	2. Name and Ad Comas F	dress of Facility uneral Hom	e, P.A.		
		40240		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	10 Kenny	13	17 Coke	sbury Road	. Abing	don, Maryl	and 21009
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.	eath. Do not ent	er the mode of	dying, such as cardiac	or respiratory a	urrest,	Approximate Interval Between Onset and Death
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		/Medical Examiner		resulting in dealin)	Due to (or as a cons	sequence of):					
1			_	Sequentially list conditions,	b. Due to (or as a cons	noguana of):					
3		ped 11sit	in in	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons	sequence or).					
10		certificate be executed ording physician and use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
1	760,	be e pician buria	cai E			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
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	×	certif iding	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pre	gnancy				23d. Date of o	lolivon
	Вох	death i	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	Ectopic pregna Other (specify			Month Month	Day Year
) @C	P.O.	the d y the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		2 C C ()	/			
	0	v requires that the death certificate been signed by the attending phys should be detached for use as the	by Pr	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
_	ds	puires							1 🗆	Yes 2□No 3□	Probably 4 Unknown
11	cord	w requir	Completed						24a. Was	an 24h Were	autopsy findings available
-	Re	The tay ate has page 2	Ĕ						auto	psy prior to	o completion of cause of
7	a	ificati	č	25. Was case referred to medical	-11 -10-3-			00 81 (8	1 Yes	2 3 No 1 □ Y	es 2 No
3	₹	Physician: this certific ral director,	o Be	examiner?	Hospital: 1 Impatient 2	ER/Outpatien		26. Place of Dea			
6	of	ding Physician: The lav n. After this certificate has funeral director, page 2	 -	27. Manner of Death	28a. Date of Injury (Month, Day Year			njury at Work?		dence 6 Other (S)	овсту)
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2		bour hour unere y fille		29a. Certifier 1 Certifying Ph	ysician: To the best of my	knowledge, death	occurred at the	e time, date and place	, and due to the	cause(s) and manner	as stated.
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		To the within 2.	Σ	29b. Signature and title of certifier				ense number		29d. Date signed (Mo	nth, Day, Year)
		4		Inn			1)	54841		5/18/0	Co
	11)		30. Name and address of person who	completed cause of death (I	1	Print)	101	01 -		1
	1,			4shkan bah	ran, M.D.	6025	. Atu	lood Kd	.Ste 20	DO Beldic	mo 21014
		Sta Registi		31. Date filed (Month, Day, Year)	32/Registrar's Sig	gnature	of Eg				•

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment of H rtificate of		ind Mer	-	iene	06	158	47
	Dhamini		1. Decedent's Name (First, Middle	Last)	-					Date of Deat Month	h Day	Year	3. Time of	Death
	Physici /Medic		MICHAEL JOHN						MA		15	2006	11:00	A.M.
	Examin	er	4a. Facility Name (If not institution,	9		CTON	4b. City, Town, o		f Death		4c. County			
			FOREST HILL HEAD 5. Social Security Number		7. Age (In yrs. I		FOREST		94 Hrs. o	Date of Birth	HAR		lana (State o	r Foreign
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			Usual Residence of Decedent		93				00	11y 25	, 1912	ricit y.	Laria	
	how how		10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside Cit	•
	and and and and and and and and and and	cto	Maryland Harfor	rd	Ве	el Air							1 🗌 Yes	2 X No
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	s 23e		841 Conowingo		dent Ever in U.	6 12	21014		in? (Casaib	Vac or No	USA	ce - Americ	an Indian	
	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Itams 23e or 28e-f show event. I're Madical Examinat must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	Armed For	ces?		Was Decedent of F If Yes, specify Cub	an, Mexican,	Puerto Rica	in, etc.)		ck, White,		
936	urs at	by	3 XVidowed 4 Divorced	If Yes, Give Year or Da	9		1 ☐ Yes Ž No	Specify:			Specif		nite	
21215-0036	72 ho	Completed	15. Decedent' (Specify only highes.	s Education	1	16a. Dece	dent's Usual Occup	oation	of working		16b. Kind of B			
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anc	ntal Hed of	Be												
Maryland	should be filed ind Mental Hygi marked othar umatic event, I	J.	Peter J. Sledz			19b. Mailir	ng Address (Street				znewsk:		Code)	
Za	and 2 sho ealth and in 27 is mu		Elizabeth Kang		hter		Conowing				-			
ē,	一工事芸		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla	1	Date		20c. Location			
E	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (Sp		state	-	y Redeeme		5_10	2_06	al+in		darrel o	For
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Sign sure of Funeral Service L	icensee	1		Name and Addre					110,	an yan	1.0.4
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			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cannot one cause on ea	aused the death ach line.	. Do not ent	er the mode of dyi	ng, such as o	cardiac or re	spiratory arre	est,		Approximate Interval Bety Onset and D	พออก
	Physician		Immediate Cause (Final disease or condition	a. pu	euron								Oriset and L	70atri
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):								
		9	Sequentially list conditions, if any, leading to immediate	b	or as a consequ	uence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Little University Cause (Disease or injury that initiated events											
0,	an an rial-tr		resulting in death) Last	Due to (or as a consequ	sence of):								
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o.	t the de by the a	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno	ant at time of de wn	eath 5L	Other (specify) _							
0	es that thighed by be detact		Part II. Other significant conditio	ns contributing to de	ath but not resu	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	acco use con	tribute to th	e cause of de	eath?
Records,	quires n sign	d by	andronge	Coth						1 🗌 Ye	s 2 🗆 No	3 Prob	ably 4 DU	Inknown
00	s been si	olete	dements)					Ė	24a. Was ar	24b.	Were autor	sy findings a	available
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of V	Physician: this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 🗆 Ir	npatient 2 🗆	ER/Outpatier	I 3 DOA		sing Home	5 Reside	nce 6 Oth	ner (Specify)	
	ding P h, After t funera	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	,	of Injury h, Day Year)	28b. Time of Injury	Wo	rk?		Describe ho	w injury occur	red		
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Division	n it fe	Certification;	4 Homicide determi	ned 200. Place buildir	ng, etc. (Specify)	eet, factory, office		201.	City or Town,	State)	Jer or nurai	HOUSE NUMBER	Jer,
	spitel lours nerel		29a. Certifier Certifying	Physician: To the	best of my know	wledge, deatl	n occurred at the ti	me, date and	place, and	due to the ca	use(s) and ma	anner as st	ated.	
	To the Hospitel or within 24 hours after To the Funerel Dircompletely filled in its	edical		xaminer: On the ba and mann	isis of examinat)
	To the Hospitel within 24 hours a To the Funerel C completely filled	Me	29b. Signature and title of certifier		-		29c. Licens	se number		29	d. Date signe	d (Month, L	Day, Year)	
•	d		Drod	5 Du			03	225	5	Y	nay 1	5, 2	006	
4	2		30. Name and address of person					119.0	Q 1	o i c	<i>E</i> :			
Ü	/ 6		31. Date filed (Month, Day, Year)	22 0	egistrar's Signar		noeth	1/	viel	ין ניסי	10		88805	
	Sta Registi		J. Date med (World), Day, Fear)	1 9 26 76	Socration Signal		Assalt 1							

			For State Registrar	State of Ma	aryland /	•	rtment of H			Reg	ene No. 2 (06	15848
	Physicia	an	Decedent's Name (First, Middle, Last) Toward Park			77			_ N	ate of Death	2 ^{Day} 06	Year	3. Time of Death
	/Medic	al	Irene 4a. Facility Name (If not institution, give str	reet and number)		1	urcotte 4b. City, Town, or	r Location o		ay 7,	4c. Count	v of Death	7:00 AMM
	Examin	er	1930 Munsey Drive	reet and tiumber)			Forest				Hart		
	Funeral Director		5. Social Security Number 6. Sex	T.T.	e (In yrs. last 96	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. D Min. Au	Pate of Birth Month, Day, Y	1909	9. Birthi Can	place (State or Foreign ntry) ada
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c, City, T	own or Loc	ation						10d. Inside City Limits
	Aaryla f eho	ō	Maryland Hartford		Fore	st Hi	11						1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number		1010	36 111	10f. Zip Code			100	. Citizen of	What Cou	ntry?
	h with	al Di	1930 Munsey Drive				21050	i		-	U.S.A		
9	be tiled within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or itema 23a or 28a-f ehow event, Itte Madical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Armed Forces? 1 ☐ Yes 2 🖾 f If Yes, Give			Vas Decedent of H Yes, specify Cuba □ Yes 2 No	ispanic Orig an, Mexican Specify:	gin? (Specify , Puerto Ricar	Yes or No- n, etc.)	Bla	ce - Amenick, White,	
Ö	hours tural',	q pe	3 → Widowed 4 □ Divorced	Year or Dates:	1	6a Deced	ent's Usual Occup	ation		16	ib. Kind of E		
Maryland 21215-0036	vithin 72 ne. han "nat	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	5+)	(Give I life. D	kind of work done of NOT use retired Board A	during most d)		1	Wester	rn E1	ectric
, 0	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, Item		8 17. Father's Name (First, Middle, Last)		0	11000	. board ?		r's Name (Firs		Manufa iden Suma		ing
aŭ	id be ental ked o ic eve	To Be	Pierre Routhier					A1e	xina B	essett	e		
ary	should band Ment and Ment marked		19a. Informant's Name/Relationship (Type	e, Print)	1	19b. Mailin	g Address (Street	and Numbe	or or Rural Rou	ute Number, (City or Town	, State, Zij	o Code)
	and 2 setth a n 27 to		Lucy Fitzgerald	(Daught			Munsey D	-		-			
Baltimore,	permit. Pages 1 and 2 should be Department of Heelth and Menta important: If item 27 is marked any injury or other traumatic e <u>pnce</u> .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			sition (Name of hatory or other place h Cemete		Date /12/06		oc. Location he1ms1		
Balt	permit. Departrimports any inju		21. Signature of Funeral Service License	Monecus		22 M	Name and Addre letropoli 517 Vine	ss of Facility tan F	uneral Alexa	Servi ndria,	ce VA 22	2310	
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused cause on each lie	d the death. I	Do not ente		ig, such as					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as	a consequen	ce of):							
	sit od	lner	day, tracing to introduce cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of							
8760,	cate be executed physicien and the burial-transit	i Examiner	that initiated events c.	Due to (or as	a consequen	ce of):							
387	physics the l	edicai	d.										
P.O. Box 6	Attending Physicien: The law requires that the death certific reath. rdeath. ector: Atter this certificate hes been signed by the attending p. by the funeral director, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	′				ate of deliv	ery Day Year
	uires that signed by lid be deta	β	Part II. Other significant conditions cont	nbuting to death b	ut not resultin	ng in the un	derlying cause giv	en in Part I.		23e. Did toba 1 □ Yes	-		the cause of death?
Records,	rhe faw requir Ie hes been si age 2 should I	Completed	 	-			· · · · · · · · · · · · · · · · · · ·			24a. Was an autopsy performe	d?	prior to co death?	opsy findings available ompletion of cause of
ita	ysician: The is certificate hi director, page	Be C	25. Was case referred to medical					26. Place	of Death (Ch	1 ☐ Yes 2∑ eck only one)	UNO	1 103	-
>	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 ☒ No Ho	ospital: 1 Inpatie	ent 2 ER	/Outpatien	3□ DOA Oth	er. 4 🗆 Nu	rsing Home	5 X Residen	ce 6 □Ot	her (Specia	fy)
Division of Vital	ath. or: After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28 y Year)	lb. Time of Injury	28c. Injur Wor M 1 🗆	yat k? Yes 2∐1		Describe how	injury occu	rred	
Divis	s after de si Directo	Certification:	3 ☐ Surcide 6 ☐ Could not be 4 ☐ Homicide determined		jury - At home tc. <i>(Specify)</i>	, farm, stre	eet, factory, office			ocation (Stre City or Town,		ber or Rur	al Route Number,
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1	ician: To the best er: On the basis o and manner st	of examination	dge, death and/or inv	occurred at the tirestigation, in my o	ne, date and pinion, deat	d place, and o th occurred at	lue to the cau the time, date	se(s) and m and place	anner as s and due t	stated. o the cause(s)
	To the To the Comp	W	29b. Signature and title of certific				29c. Licens		2		Date sign		Day, Year)
Î	1		30. Name and address of person who con		death (Item 23	Ba) (Type, I							
	Sta Registi		31. Date filed (Month, Day, Year)	169	rar's Signature) h						
DH	MH 17 Rev 1/2		MAY 1 9 2006	1 dillie	1	The state of the s							

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		τ.	For State Registrar	State of	f Marylar		artment of I rtificate of		and Me	ental		ene (2006	1584	9
	Dhysisi	20	1. Decedent's Name (First, Middle,	7						2. Date Mont	of Death h	Day	Year	3. Time of Death	
	Physici /Medic		Shirley T	round							5	15	2006	2:50 p M	
	Examin	er	4a. Facility Name (If not institution,	give street and nun	nber)		4b. City, Town,	or Location o				4c. C	ounty of Death		
				3139 Elmora		to a biat to b	If I lader 1 Veer	If Under 2	Baltim					/A	_
П	Funeral		5. Social Security Number 216-34 - 4188	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	Vre	If Under 1 Year Months Days	Hours	Min.	8. Date (Mon	of Birth th, Day,	Year)	Cou		
	Director		Usual Residence of Decedent	/•	6	7				05	53/1	138		Maryland	_
	land ow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							0d. Inside City Limits	_
	Mary Feb	ţ	Maryland	N/A			E	Baltimore	•					1 XYes 2 No	
	the 728a	Director	10e. Street and Number				10f. Zip Code				10	g. Citize	n of What Cou	ntry?	_
	3a o	<u> </u>	3139 Elmora Avenue					2122	23				U.S.	A .	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or iteme 23a or 28a-f ehow event, the Medical Examinat must be redified at	Funeral	11. Marital Status	12. Was Dece		J.S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Orig	gin? (Spec	ify Yes	or No-	14	. Race - Amen		_
9	after or its		1 Never Married 2 Marrie	Armed For	2 No				, Pueno A	ncan, et	C.)		Black, White,	etc.	
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2	filed w Hygie other ti	ខ	12 17. Salhada Naza / Sizat Middle /				nealth	Care Pro		/Cirot A	district A.A.	- id C	1		
פת	be fi	Be	17. Father's Name (First, Middle, L	llie Morton				18. Mothe	r s ivame				Morton		
$\frac{3}{5}$	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow then treumatic event, I'm Madical Examinat must be notified at	2				10h M-35-			D /					0-4-1	_
Maryland 21215-0036	" = m 3		19a. Informant's Name/Relationsh Lisa Thomas	ip (Type, Print)			ng Address (Stree 414 Epic Ga					Uny or I	own, State, Zip	Code/	
	1 and Health em 27 ther ti	1	20a. Method of Disposition		20b. I		sition (Name of	C DOWN	Da			nc Loca	tion - City or To	own State	_
وّ	Pages nent of I int: If its iry or o		1 XBurial 2 Cremation			cemetery, crer	natory or other pla						-		
Baltimore,			4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	-		A .	ardens of Fa)5/20/	06	VVI	nie Marsn	, Maryland	_
Ba	Departit Departit Imports any nju	7	21. Signatura of Pulleral Service L	1 50	tons	P "				al Sen	vice. P	. A.			
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that co	aused the deal	th. Do not ent	1300 E	Brothers utaw Pla	ce Bal	timore	Md 2	21217	7	Approximate	_
PI / E	Physicien and buysicien and buysicien and physicien and physicien and strength and physicien and phy	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ce Due to (Due to (or as a consector as	quence of):	CUTY SY		rbg	74	و			Onset and Death	
O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		inth 2 ☐ Feta ant at time of o	aldeath 3□	Ectopic pregnanc	y				230	d. Date of delive Month	ery Day Year	
J	that	by Pi	Part II. Other significant condition	ns contributing to de	ath but not res	sulting in the u	nderlying cause gr	ven in Part I.		23e.	Did toba	cco use	contribute to t	ne cause of death?	
g	quires n sign	d b	(2000)	nerson	Syle						1 🗆 Yes	2	No 3 ☐ Prob	ably 4 Unknown	
<u>o</u>	w require been si should I	Completed		(, , , , , , , , , , , , , , , , , , ,	1					24a.	Was an	T	24b. Were auto	osv findings available	-
Ä	he lav e has ige 2	Ĕ									autopsy	ed?	prior to co death?	psy findings available mpletion of cause of	
ā	ifficet or, pe		25. Was case referred to medical			<u>.</u>		OS Blace	of Death	(Chaok		No	1 🗆 Yes	20 No	-
>	s cert	To Be	examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2] ER/Outpatier	nt 3 DOA Ot	hor	rsing Hom	. /	Residen	° 6 [☐Other (Specif	w)	-
5	a Physical of this eral of		27. Manner of Death	28a. Date	of Injury	28b. Time of					cribe how			//	_
0	nding th.: After e fun	at lo	Natural 5 Pending 2 Accident investig		h, Day Year)	Injury		irk?]Yes 2∐1	No						
Division of Vital Records,	To the Hospitel or Attending Physician: The I within 24 hours effect death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification;	3 Suicide 6 Could n 4 Homicide determi	200. Place	of Injury - At h	ome, farm, str	eet, factory, office		21	8f. Loca City	tion (Stre or Town,	et and I State)	Number or Rura	l Route Number,	_
	he Hospit n 24 hour he Funera	Medical (29a. Certifier TK Certifying (Check only one)	Physicien: To the examiner: On the ba and mann	asis of examina	owledge, deatl ation and/or in	n occurred at the t vestigation, in my	ime, date and opinion, deat	d place, ar th occurre	nd due t d at the	o the cau time, dat	ise(s) ar e and pl	nd manner as s ace, and due to	tated. the cause(s)	_
	To the To the comp	Σ	29b. Signature and title of certifier				29c. Licen	se number	/		290	d. Date s	signed (Month,	Day, Year)	
)				NYN	10		D3	4146	2		-	7/1	8195		
1	19		30. Name and address of person v	vho completed caus					,,			1	-1-0		_
U	l		Murrayh	65+MO	4	Mbs	y High	e Bo	197	M	e M	11)	2121	პ	_
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32.	egistrar's Sign	ature	cardes								

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	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Las Michele 4a. Fecility Name (If not institution, give	Diane V		4b. City, Town	n, or Location of Dea		Day Year 9 06 4c. County of Dea	,
	Funeral Director		5. Social Security Number 6. Se 217-78-3417	TM 21STF	(In yrs. last birthda 45	Months Da		s. 8. Date of Birth	ear) C	rthplace (State or Foreign ountry) MD
	he Maryland 8a-f ehow	ector	Usual Residence of Decedent 10a. State 10b. County MD Howard		10c. City, Town or	1				10d. Inside City Limits 11€ Yes 2 □ No
9036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itama 23e or 28e-f ehow any njury or other traumatic event, the Medical Examinar must be notified at ances.	d by Funeral Director	10e. Street and Number 12486 Lime Kiln 11. Marital Status f □ Never Married 2⊠ Married 3□Widowed 4□Divorced	Road 12. Was Decedent E- Armed Forces? 1	ver in U.S. 1	10f. Zip Cod 2075 3. Was Decedent of f Yes, specify C	59 of Hispanic Origin? (cuban, Mexican, Pue		USA 14. Race - Am. Black, Whi Specify: WI	erican Indian, te, etc.
ınd 21215-0036	be filed within 72 h tal Hygiene. d other than "natu event, the Madica	Be Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		·) (G	cedent's Usual Oc ve kind of work do b. DO NOT use rel	ne during most of witired)	orking	Own Home	vIndustry
ore, Maryland	es 1 and 2 should of Health and Man item 27 is marke r other traumatic.	ဥ	James A. Thomas 19a. Informant's Name/Relationship (7) John A. Veasey/Hu 20a. Method of Disposition	sband	124		eet and Number or F	ou Trible Gural Route Number, C Fulton, M Date 200		
Baltimore,	permit. Pages Depurtment of I Important: if its any njury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens Communications of Communications Communications of Communications	Mmen	Cremato	ry 22. Name and Ad	dress of Facility I	Hoffman Fun 409 Main St Boswell, PA		
	icate be executed physicien and physicien and physicien and physicien and street is the burial-transit	al Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Septic Use to (or as a Renaule.	consequence of):	Brent e		ac or respiratory arrest,		Approximate Interval Between Onset and Death
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ords, P.	w requires that t been signed by should be deta	β	Part II. Other significant conditions co	ntributing to death but Diabeles		underlying cause	given in Part I.			o the cause of death? robably 4 Unknown
tal Rec	rsician: The law is certificete has bilirector, page 2 st	e Completed	25. Was case referred to medical	-			26 Place of De	24a. Was an autopsy performed 1 Yes 2 2	prior to death?	utopsy findings available completion of cause of 2 No
Division of Vital Records,	ding Phy	ToB	examiner?	Hospital: 1 Anpatient 28a. Date of Injury (Month, Day)	28b. Time	of 28c. Ir	04	Home 5 Residence 28d. Describe how i		icity)
Divis	pital or Atteneurs efter deathers eral Director:	Certification;	3 Suicide 6 Could not be determined	28e. Pface of Injur building, etc.	(Specify)			28f. Location (Stree City or Town, S	tate)	
)	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier Australia (Check only one)	sician: To the best of iner: On the basis of e and manner state	examination and/or	investigation, in m	y opinion, death occ	ee, and due to the cause curred at the time, date 29d.	and place, and due	to the cause(s)
2	Sta Registr		30. Name and address of person who c KA: 5ER HAMAD 31. Date filed (Month, Day, Year) MAY 1 9 2006	Dompleted cause of dea	ath (Item 23a) (Type (S) (Type) (S) (S) (Type) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	e. Print)	GENERAL	5 29d.	L	

06-03310			Please Type or					
Patrick H. Walker	, Sr	State o	of Maryland / Depa			lygiene	0.0	
		- For State	Cer	tificate of Dea	ath	Reg.	. No.	16 585
Physician		egistrar i. Decedent's Name (First, Middle, Last)	1			2. Date of Death	Noor Year	3. Time of Death
Medical Examin		Patrick Le	nru Wall	KOV SV		Month [May 16, 200	Day Year D6	1444 hrs
Medical Examin		la. Facility Name (if not institution, give	street and number)	4b. Cit	y, Town, or Location of Deat		4c. County of Dea	th
		6 Kings Crossing Court # C		Co	ckeysville		Baltimore Co	unty
				act hirthday/\ If II	nder 1 Year If Under 24Hr	s 8. Date of Birth	(MM/DD/YYYY) 9. B	irthplace (State or
Funeral	- 1	210 == Ciech /	,		nths Days Hours Mi	_	Fore	
Director		219-22-8287101	M 2 F	Yrs.		11-20	-17/2	ouring VCWYCAL
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or 2	Director	Lac Kings	77/1/		21030		USH	•
eath with the Maryland items 23a or 28a-f show ust be notified at once.		11. Marital Status	12. Was Decedent Ever in U.	.\$. 13. Was Dec	edent of Hispanic Origin? (Specify Yes or No-		erican Indian, Black,
ath w	uneral	1 Never Married 2 Married	Armed Forces?	If Yes, sp	ecify Cuban, Mexican, Puerl	to Rican, etc.)	White, etc.	i - 1
or de	리	3 Widowed 4 Divorced	1 Yes 2 No	1 Yes	2 No specify:		Specify: W	hite
s afte	2	15. Decedent's Education (Specify only	or Dates:		ual Occupation (Give kind o	f work done	16b. Kind of Busines	s/Industry
hour natu Exar	g .	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of	working life. DO NOT use re	etired)	:	,
6 n 72 n 72 ical	흵	Elementary/Secondary (0-12)	College (1-4 di 3.)	Build	ing Contro	into 1	P H.	Walker
5-0036 filed within 77 Hygiene.	Completed	1 4		13 00110		ne (First, Middle, Ma		
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nould la Mer	입	19a. Informant's Name/Relationship (Ty	/pe, Print)			Rulai Rodie Nami	, , ,	160
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after doment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner m.		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposition (crematory or other place	ace)	1	_	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be fited within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	}	1 mg Mrs		Cent	~ 2325 JOCK	id Do	20.3402 12	021003
	-	23a. Part I. Enter the disease or compl	lications that caused the death	n. Do not enter the mo	de of dying, such 's cardiad	or respiratory arres	st, shock, or heart	Approximate Interval
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		of condition resulting in death)	Due to (or as a consequence of	oi).				
	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	of):				
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87 tifice as th	Ju.	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	eath 3 Ectopic preg	nancy	Month	Day Year
x 6 h cer tendi	:3		4 Pregnant at time of d	leath 5 Other (Specify)			
Bo deal	hys	1 Yes 2 No 9 Unknown	9 OHKHOWIT			CO2- Did to		to the cause of death?
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l dire	0	1 Yes 2 No	T Inpatient 2	ER/Outpatient 3			Residence 6 🗸 Ot	ner: Scene
ing Pl ing Pl After Lunera	ä	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		28d. Describe n	ow injury occurred	
Division of 'pital or Attending Phours after decora: After there all Director: After tilled in by the funeral	Certification:	1 Natural 5 Pending	ion		1Yes 2No			
ivisior or Attend after death. Director:	<u>:</u> 2	2 Accident Investigati 3 Suicide 6 Could not	28e Place of Injury - At	home, farm, street, fa	ctory, office building, etc.			Rural Route Number, City
Div	Ē	3 Suicide 6 Could not determine				or Town, St	tate)	
D Hospital 24 hours Funeral tely filled		29a. Certifier	ian: To the best of my knowle	edge death occurred	at the time, date and place,	and due to the cause	e(s) and manner as s	tarted.
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one) 2 Medical Examine	r:On the basis of examination	and/or investigation,	in my opinion, death occurre	ed at the time, date a	and place, and due to	the cause(s)
S. S. Barrens	Ped	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (
	2	29b. Signature and title of certifier	10		O.C.M.E.		May 17, 2006	
	1	Langela?	1		J. 5.111.E.		L	
	1	30. Name and address of person who				24204		
		Zabiullah Ali, M.D. Assi	istant Medical Examine		treet, Baltimore, MD	Z1ZU1		
S	tat	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature				
Regis	stra	MAY 1 9 200	10 Herens L	1 Goste	<i>y</i>			
DHMH 17 Rev 1/2	2001			ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Amend item#20b-c.22 perFH, DVR, G855, 5/22/06 TT State of Maryland / Department of Health and Mental Hygiene Amend item 20a per fh g855 & 25 To the Wif Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner ealthca/ 9 HGNES 5. Social Security Number 6. Sex 1 M 2 □ F 'ear | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days 244-18-475: 85 Hours Min Yrs. Director Usual Residence of Deceden *oho 10a. State 10b. County City, Town or Location 10d. Inside City Limits the Medical Exerciner must be notified at Director MD 1 Yes 2 □ No 28a-f 10e. Street and Number 10g. Citizen of What Country? ō 207 3121 or Items 23a Funeral Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Ever in U.S. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) al Hygiene. ndary (0-12) College (1-4or 5+) oreman 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be in Department of Health and Mental Important: If Item 27 Is marked o 19a. Informant's Name/Relationship, 19a. 19b. Mailing Address (Street and Na ber of Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition osition 3 Removal from State Garrison 1 Burial injury or 4 Donation 5 Other (Specify) 21. Si ya Baltimore, ure of Fur any it 3/22 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death atheroscientre Immediate Cause (Final disease or condition resulting in death) Physician cardiovascular nun aug /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sicien and e buriai-transit Due to (or as a consequence of): Physician/Medical the phys as attending for use as IF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ as been signal 1 🗌 Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient this 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М Director: 6 ☐ Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after to the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47353 Mny 17, 2006 30. Name an address of persol who completed cause of death (Item 23a) (Type, Print) · talex M.D 900 caton Avenue Baltimore St. Agnes Hospital JON 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 9 2006 Registrar

		1	For State Registrar	State of	Maryland /	•	artment tificate				ental Hy	giene Reg. No	006	15853
	Physicia		Decedent's Name (First, Middle Decedent's Name (First, Middle)		WALTER	4				-	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	ICAVEN 4a. Facility Name (If not institution)				4b. City, T	Town or	Location		May	40.0	County of Death	
7	Examin	er	4918 Clermont N	=	61)				svil]				arford	
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs, last bi	irthday)	If Under 1	/	If Under Hours	A	8. Date of Bir (Month, Da	th		nplace (State or Foreign untry)
	Director		181-56-5320	1 □ M 2 🔼 F	33	Yrs.	Months	Days	Hours	WIII.	JÜLŸ 3	0 1 97	2	MD
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Lo	cation							10d. Inside City Limits
	Aarylis f sho	٥	MD Hari	Ford			/ille							1 ☐ Yes 2 🖾 No
	28a-	Funeral Director	10e. Street and Number				10f. Zip (Code				10g. Citize	en of What Co	untry?
	h with		4918 Clermont N	Mill Road			2	21132	2			US	SA	
	deat	ner	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. \	Was Decede	ent of His	spanic Or	rigin? (Spec	cify Yes or No Rican, etc.)	o- 14	1. Race - Ame Black, White	
36	or It	by Fu	1 X Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give	_		1□Yes 2		Specify				annih a	hite
21215-0036	n 72 hours after death with the Maryland "neturel", or Items 23e or 28a-1 show polical Externity of the notified at	ed b	15. Decedent	Year or Date		a. Deced	dent's Usual	I Occupa	ation			16b. Kind	d of Business/l	
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pu	be filed within 72 hc ital Hygiene. id other than "netul event, ∏e Medical	Be	17. Father's Name (First, Middle,								(First, Middle			
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Ma	2 sar		Daniel Walter,				•				Red 1	-		7356
	s 1 and strength Health item 27 other tr		20a. Method of Disposition		20b. Place			the second	7		ate		ation - City or	
E O	Pages nent of I int: If its iry or o		1 ☐ Burial 2 A Cremation 4 ☐ Donation 5 ☐ Other (S)		ater i		ke Cre			5/20/2	2006	Belts	sville,	MD
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service	icensee	. Loh	nrmann	, PA	son, MI						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death. Do							,	•	Approximate Interval Between
	Pnysician	6 10	Immediate Cause (Final disease or condition	G	stric	Cai	ncer							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence	of):								
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9760	icate be executed physician and s the burial-transit	Ical		d					···	_				
9	rtifica ng ph s as th	Med	IF FEMALE:	1										
Вох	eath certific attending p I for use as I	Physician/Med	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal deat		Ectopic pre					23	3d. Date of deli Month	very Day Year
0	res that the de signed by the a be detached f	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknow	nt at time of death n	2	Other (spe	эспу)						
Ω.	that t	y Ph	Part II. Other significant condition	ons contributing to dea	th but not resulting	in the u	nderlying ca	ause give	n in Part	l.	23e. Did	tobacco us	e contribute to	the cause of death?
Sp	quires n sign ald be	d by									10	Yes 2	(No 3□ Pro	obably 4 Unknown
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed									24a. Was	psy	prior to d	topsy findings available completion of cause of
E B	ding Physician: The n. After this certificate h: funeral director, page	Con									1 Tes	ormed? 200 No	death? 1 ☐ Yes	2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				. Othe			(Check only		FIG	
of	Phys r this ral di	To To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury 28b.	. Time o		Bc. Injury Work	4 🗀 14		8d. Describe		Other (Special occurred)	city)
lon	Attending F r death. ector: After by the funera	atlor	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	9	Day Year)	Injury	М		<br Yes 2. []No				
Division	r Attendi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could determ	ined 289. Place o	f Injury - At home, to, etc. (Specify)	farm, str	reet, factory,	, office		2	8f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
	Ital or A rs after rel Direc led in by													
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical		g Physician: To the b Examiner: On the bas and manne	is of examination a									
	To th within To th compl	Me	29b. Signature and title of certifie	1. 1.11	- 7		29c.		number	-/		1	signed (Month	4
	d		Cela Cli	aterful	Mrs-			02	43	56		Ina	14 19,	2006
	12		30. Name and address of person Win C WATERFI		of death (Item 23a) (Type,	Print) W	Sinh	ey Co	nen i	Instituted Bol	ti at	Fronkle Mrs	21237
: 0	Sta Regist		31. Date filed (Month, Day, Year)	006	gistrar's Signature	e a	Sign of							

State of Maryland / Department of Health and Mental Hygiene 2006 15854 Certificate of Death 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 200<u>6</u> Month **Physician** 17 9:44 AMMay Margaret Wanken /Medical 4a. Facility Name (If not institution, give street and number)
2401 Bachman Valley Rd. 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Manchester If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). 8. Date of Birth Month, Say, Year 921 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Min. Maryland 219-18-0193 1□M 2\ F Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 1 Yes 2 No Manchester Md. Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r then "neturel", or Iteme 23a or the Medical Examiner must be 2401 Bachman Valley Rd. 21102 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carroll Co. School Bd. Reader 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked other you or other traumatic event Mary V. Clayton Robert Pahr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William E. Wanken, Sr.-Husband 2401 Bachman Valley Rd., Manchester, Md. 21102 Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory of other place)

1 Burial 2 Cremation 3 Removal from State Baltimore National Cem. May 19, 2006 Baltimore, Md. 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eune/al Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical · Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien at s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 0 No 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 3□ DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and MD029689E and address of person who completed cause of death (Item 23a) Type, Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State	e of Maryla		artmen rtificat				lental H	ygien Reg. N	211	06	158	55
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of D	D:	ıy	Year	3. Time of D	
	/Media	_	Syed Hamid Ali					-			May	2,	200		18:10	P
	Examir	ier	4a. Facility Name (If not institution, Holy Cross Hosp:	-	number)				Location of				County of Conty		v	
	Funeral			6. Sex	7. Age (In yrs	s. last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of B			9. Birth	place (State or	Foreign
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	pu k		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	ocation								10d. Inside City	Limite
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	deat ms 2	ner	11. Marital Status		Decedent Ever in decedent Ever in decedent	U.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	lo-		- Ameri	can Indian,	
36	or Ite	y Fu	1 Never Married Marrie	ed 1 🗀 Y	es 2∭No , Give	1	1 ☐ Yes		Specify:		Thousand Octoby		Specify:		ian	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show the Madical Exemples must be notified at	Completed by	3 Widowed 4 Divorced		or Dates:	16a. Dece	dant's Heur	al Decum	ation			165	(ind of Bus	inoer/le	ductor	
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Maryland	C1 G2 = 0		19a. Informant's Name/Relationsh Syed Asif Ali -								al Route Num.				code) d 20904	,.
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Вох	feath certifica attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		, outcome of pregr ive birth 2 ☐ Fe		Ectopic pr	egnancy				1	23d. Date			
	ne des the at hed fo	/s c	1 Yes 2 No		regnant at time ot Inknown	death 5	Other (sp	ecify)					MON		Day Ye	al
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Records,	uires thai signed t Id be det	d by					, ,					Yes 2			ably 4 ∰Un	
00	w require been si should b	ete									24a. Wa	s an	24b. W	ere auto	psv findings av	/ailable
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of Vital	sician: The law certificete has b irector, page 2 s	BeC	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only				2□ No	
>	iding Physician: th. : After this certifice funeral director, p	To	examiner? 1 □ Yes 2 No			☐ ER/Outpatier	ıt 3□ DC	Othe Othe	9F: 4 □ Nu	rsing Ho	me 5□Res	idence	6 Dother	(Specif	v)	
0	ing P	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. D	ate of Injury Month, Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how inju	ry occurre	d		
sio	Attending ir death. ector: Aftei by the fune	cat	2 Accident investigation 3 Suicide 6 Could not	ot be	Name of takens At I	<u> </u>	М		Yes 2□I		204 1	(04	-1.84 6			
Division	after all or A	Certification:	4 Homicide determin	led 286. P	Place of Injury - At I uilding, etc. (Spec	nome, larm, str cify)	eet, tactory	/, office		1	City or To	Street a	a Numbe e)	r or Hura	I Route Numbe	3r,
_	spite		29a. Certifier 12 Certifying	Physician: To	the best of my kr	nowledge, deatl	n occurred	at the tim	e, date an	d place, a	and due to the	cause(s	and man	ner as s	tated.	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E	xaminer: On the	he basis of examin manner stated.	nation and/or in	vestigation	, in my op	oinion, deat	th occurr	ed at the time	, date an	d place, ar	nd due to	the cause(s)	
	To the within To the Comp	Σ	29b. Signature and title of certifier	4. ~	, -		290	. License	number	3. 0		29d. Da	te signed	(Month,	Day, Year)	
	V		A Na	may	· wo			D 2	098	千	-	5	- 3	- (56,	
			Name and address of person w		cause of death (Ite	om 23a) (Type,	Print)		\E.	wh	110.0	mn	20	223	2 .	
				1A2 N	2 Baffetrar's Sing	OX 5 55	19	Jul	11/2	r50	ing	,0		202	· ·	
6	Sta Registr		31. Date filed (Month, Day, Year) MAY 0	5 2006	Marie	1. A	post	,								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 11:00P M 2006 April 29, Barnard /Medical Ernest Leroy 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 865 Yardarm Way Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Jan. 23,1922 Wash. D.C. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 XM 2 ☐ F Director 213-12-1726 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f ehow ir then "neture!, or iteme 23a or 28a-f eho 1 Yes 2 No Directo Maryland Annapolis Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 865 Yardarm Way 21401 USA Funeral Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
ant: If item 27 is marked other then "neturei", or Iteme 23, ury or other frauntalic event, if a Medical Exemplicat matter. 12. Was Decedent Ever in U.S. Armed Forces? 1 (XYes. 2 □ No. 1942— If Yes. Give Year or Dates: 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White ģ 3 Widowed 4 Divorced 1962 Be Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supply Officer US Air Force 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice V. Brown Alexander F. Barnard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 865 Yardarm Way Annapolis, MD. 21401 Helen V. Barnard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of importent: If eny injury or once. MD. Veterans Cemetery 5/3/06 Crownsville, MD. 22. Name and Address of Facility Geo. P. Kalas Funeral Home Funeral Service License 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Stomach Immediate Cause (Final Physician Cancer years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52830 May 1,2006 canne were MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeanine Werner, 900 Bestgate Road #300, Annapolu, MD 2140/ 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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			1- For State Registrar	Certif	icate of l	Death		R	eg. No.	0 1000
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edical	Exami	ner	Taylor Olivia Blush 4a. Facility Name (if not institution, give street and number)	1	. I 4h	City Town o	r Location of D	April 27, 2	4c. County of Death	
			Anne Arundel Medical Center		- 1	Annapolis	. Loodion of L	, out i	Anne Arundel	
Fu	uneral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9. Bir	
Di	rector		215-69-9128 1_M 2XF	2	Yrs.	Months Da	ys Hours	Min. March	n 27 2004 Foreig	untry) Maryland
	*		Usual Residence of Decedent							
	w any		10a. State 10b. County MD Calvert		wn or Location $\mathbf{r}\in \mathbf{Fr}\epsilon$					10d. Inside City Limits 1 Yes 2 X No
yland	28a-f show d at once.	ġ	10e. Street and Number	FIII		10f. Zip Code		Ta	0g Citizen of What Cour	
e Mar	i 23a or 28a-f show notified at once.	Director				206	70		USA	nt y ?
vith th	s 23a e noti	퍨	425 Heron Landing Way 11. Marital Status 12. Was Decedent	Ever in U.S.	13. Was			? (Specify Yes or No		can Indian, Black,
leath v	r item	Funeral	1 X Never Married 2 Married Armed Forces?					uerto Rican, etc.)	White, etc.	
after o	al", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		_	es 2 X N			Specify:	nite
hours	Exam		15. Decedent's Education (Specify only highest grade com		Sa. Decedent's during mos	Usual Occup t of working lif	ation (Give kine e. DO NOT us	d of work done e retired)	16b. Kind of Business/I	ndustry
36 in 72	han " dical J	Completed	Elementary/Secondary (0-12) College (1-4 or 6	o+)	Nev	er Wor	ked		_	
-00-	Hygiene other than the Medical	팅	17 Father's Name (First, Middle, Last)				18.Mother's N	Name (First, Middle, I	Maiden Surname)	
215 be file	rked c	Be (Jason	Blush	n		Lisa		Shar	ma
21 hould	is ma	은	19a Informant's Name/Relationship (Type, Print)						nber, City or Town, State	
M Z s	alth arm 27		Jason Blush (father) 20a Method of Disposition	20h Play	425 He		_	-	ce Frederich	•
ore,	nt of Health and Mental I nt: If item 27 is marked other traumatic event,		1 X Burial 2 Cremation 3 Removal from Sta	ate crer	natory or othe	r place)		May 2,		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland	rtant:		4 Donation 5 Other Specify: 21. Signature of Experimental Service Licensee	Sout	hern M			2006	Dunkirk, la Home Calv	
Bal	Depart Impor injury	Lvd Owings,								
	Physician 23a. Part I. Enter the discress, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.									
	edical miner		Immediate Cause (Final disease a. Drowning							Between Onset and Death
			or condition resulting in death) Due to (or as a conse	equence of):						
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	equence of):						
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, se exec	physician and the burial - transit	/Medical	UNPENDED AMENDED						· -	
760, icate be	physi the bu	/Me	IF FEMALE: 23c. If yes, outcor 23b. Was decedent pregnant in the	ne of pregnar					23d. Date of delivery	
Box 68 death certif	ending use as		past 12 months?	time of death	2 Feta	r (Specify)	Ectopic pr	regnancy	Month E	ay Year
Bo)	the att	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown			(-,,-,			1	
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Rec ™	icate }	Con						1 🗸 Yes		s 2 No
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of C	After this certificate I funeral director, page	: To	27. Manner of Death 28a. Date of Inju	iry 28	Bb. Time of Inj		ury at Work?		Residence 6 Other	:
on C	ath pr: Af he fun	tion	1 Natural 5 Pending Apr 27, 2006	ear) 1	015 hrs	1	Yes 2 🗸 N	Subject drov		
Division of Vital Records, P.	ter de irecto in by t	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In	jury - At home	e, farm, street,	factory, office	building, etc.		Street and Number or Ru	ral Route Number, City
	ours after death teral Director: filled in by the	Certification:	4 Homicide determined (Specify) Sw	imming Po	ool			or Town, S 1208 Latrob	pe Dr, Annapolis, M	D
Division of Vital Records, P.O. Box 68760, To the Hosnital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier 1 Certifying Physician: To the best of mone) 2 Medical Examiner: On the basis of examiner: On the basis of examiner:							
Tot	To the	Medical	29b Signature and title of certifier	aion and/	vestigatic		nse number		29d Date signed (Moi	
		7.5	Carrell Lann.				.M.E.		April 28, 2006	, 20,, , 00.,
			30. Name and address of person who completed cause of c	leath (Item 23	(a)	2000		1221		
3		i	Carol Allan, MD Assistant Medical Exar	miner 11	11 Penn St		nore, MD 2	1201		
	S Regis	tate	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	Kna	A. B				

06-03105 Arnold R. Brown

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	- 1	1- For State Certificate of Death Registrar	Reg. No. 20	05 1585
Physicia Medical Exami		A 1 - 1 D-1 D	n Day Year	3. Time of Death 0539 hrs
viedicai Exami	llet	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	8, 2006 4c. County of D	
		Calvert Memorial Hospital Prince Frederick	Calvert	
Funeral	\neg	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date Months Days Hours Min.	e of Birth(MM/DD/YYYY) 9	8irthplace (State or preign D.C.
Director		213-06-5790 1X M 2 F 37 Yrs. Oct	. 7, 1968 V	ashington,
any	ŀ	Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location		10d. Inside City Limits
Aaryland 28a-f show any 1 at once.	ь	MD Calvert Co. Prince Frederick		1 Yes 2 XNo
Maryl r 28a-f ed at o	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What (Country?
ith the			U.S.A.	merican Indian, 8lack,
eath w items	Funeral	Armed Forces? Never Married 2 Married 2 Married		
after d al", or	by Ft	3 Widowed 4 Divorced if res, give rear or Dates:	Specify: Wh	ite
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15-0036 filed within 72 hours after death with the Maryland Hygiene ed other than "natural", or items 23a or 28a-f sht t, the Medical Examiner must be notified at once	Completed	12 Electrician	Local U	Inion #26
5-06 led win Hygier other				-
AD 21215 2 should be file 1 and Mental Hi 27 is marked of matic event, th	o Be			tata Zin Codo\
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene 127 is marked other than umatic event, the Medica	Ĕ	Brenda A. Brown (Wife) 2030 Jessica Lane, Prince		
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date		
Pages nent of ant: I		A Donation 5 Other Specify: Chesapeake Highlands 2006	Port Rep	oublic, MD
Baltimore, permit Pages 1 a Department of He Important: If ite		21. Signature of Linear Service Idensee 22. Name and Address of Facility Lee Fun 8125 Southern Maryland		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate		Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone intoxication		Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of)		
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that the degree by the second the second the second detached for	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	. Did tobacco use contribut	e to the cause of death?
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ical	28a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time		
To the within To the Complet	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed	(Month, Day, Year)
		Pet. Quan i -telle s O.C.M.E.	May 9, 2006	
		30. Name and address of person who completed cause of death (Item 23a)		
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201	
S Regis	tate trar			

			For State	State of Maryland	/ Department Certificate				15859
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Ochmeate	or Death	2 Oate of Dea	eg. No.	3. Time of Death
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	me 2	nera		2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decede	ent of Hispanic Origin	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after ane. than "natural", or ite na Madical Exaction	by Funeral Director	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2				Vhite.
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and	be file	Be	17. Father's Name (First, Middle, Last) William (C. C.	haffell	Sm	18. Mother's	Name (First, Middle,	Maiden Sumame)	0 - 1010
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Je,	of Heals fitem 2 r other		20a. Method of Disposition	20b. Plac	e of Disposition (Nametery crematory or other	e of her place)	Date	20c. Location - City	Town, State
Ë			1 Paurial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	moval from state Jeh	OW TAPI	015 5	10/06	Temp,	VA.
Baltimore	permit. Peg Department important: eny injury c once.		21. Signiture of Funerat Service License	fort	22. Name and	Address of Facility APA APA APA APA APA APA APA A	Home	234	UA 42
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Division	To the Hoepital or Attending I within 24 hours eitar death. To the Funeral Director: After completaly filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At home building, etc. (Specify)	e, farm, street, factory,	office	28f. Location (Si City or Town	treet and Number or Ru n, State)	ral Route Number,
	ours e		29a. Certifier 1 Certifying Phys	ician: To the best of my knowle	edge, death occurred a	t the time, date and r	place, and due to the c	ause(s) and manner as	stated
	To the Hoepital within 24 hours e To the Funeral I completaly filled	edicai	(Check only 2 Medical Examinate)	er: On the basis of examination and manner stated.	and/or investigation,	in my opinion, death	occurred at the time, d	ate and place, and due	to the cause(s)
	To the To the Comp	W	29b. Signature and title of certified			License number	2	9d. Date signed (Month	,
	9.0		I (m Ju)	>		H7047		5/5/06	
	0 Mg		30. Name and address of pers who co	npleted cause of death (item 2)	3a) (Type, Print)	C4 <:	1:-6 -	5/5/06 ND 2/8	237
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur			ISDUTY.	110 218	
	Registr		MAY 0 5 20	106	4 Sounds	,			

		1 - For State Registrar	State of Marylan	•	irtment of H			Hygiene Reg. No. 2006 15860			
Physici /Medic		1. Decedent's Name (First, Middle, Last) Ann Hale	es	Coker			2. Date of Death Month May 4,	Day 2006	3. Time of Death 5:15A.		
Examir		4a. Facility Name (If not institution, give st Somerford Assisted	Living		Columb			4c. County of Deat Howard			
Funeral Director		5. Social Security Number 6. Sex 578-24-3353	7. Age (In yrs.	79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Ye Sept. 21,	1926 Ohi	nplace (State or Foreig untry) O		
Maryland s-f show		10a. State 10b. County Maryland Howard	10c. Cit	y, Town or Lo Columb					10d. Inside City Limits		
th with the 23s or 28s	ai Direc	10e. Street and Number 8220 Snowden River	Parkway		10f. Zip Code	21045		Citizen of What Co United St			
urs after dee ai', or itame	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba ☐ Yes 2∑ No		pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify:			
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Department: If term 27 is marked other than "natural; or itame 23e or 28e-f show eny injury or other treumatic event, Ita Medical Exaction must be notified at appres.	To Be Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done of OO NOT use retired	during most of work	king	. Kind of Business/	industry		
		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)									
		19a. Informant's Name/Relationship (Typ Christopher P. Coke		4	-		ral Route Number, Cit Consville,				
Pages 1. ment of He ient: If iten jury or oth		20a. Method of Disposition 1 ፟ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State Gat	emetery, crer te of l		metery 5/	/8/2006 Si		ng,Marylan		
Depart Depart Import eny in		21. Signatur ral Service Licensee	and I	DO 44	nald V. I 00 Powder	Borgwardt Mill Ro	Funeral H ad Beltsvi	Home, PA ille, Mar	yland 2070		
Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, of heart failure. List only one immediate Cause (Final disease or condition resulting in death)	cause on each line. Amyloidosis Due to (or as a conseq		or the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death 3 years		
Attending Physician: The law requires thet the death certificate be executed reads to death. The law records to death certificate has been signed by the attending physicien and ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseq								
	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year			
	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia					23e. Did tobacc	se. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkno			
	Complet						24a. Was an autopsy performed	? prior to death?	topsy findings availab ompletion of cause of 2 No		
	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Worl	er: 4 🗆 Nursing Ho		Check only one) 5 ☐ Residence 6 ②Other (Acesisted Liv d. Describe how injury occurred			
To the Hospital or Attending is within 24 hours attended to the Funerel Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,		
in 24 hour the Funer pletely fill	Medical	one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or in	restigation, in my of	oinion, death occur	red at the time, date a	and place, and due	to the cause(s)		
To the P within 2-	2	29b. Signature and title of certifier			29c. License D432			May 4, 2			
		30. Name and address of person who con Paul Armstrong, M. I	D. 14201 Laur	el Par	k Drive I	Laurel, M	laryland 20	707			
Sta Regist		MAY 0 5 200	32 Registrar's Signa	4 60	will						

State of Maryland / Department of Health and Mental Hygiene UUD Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 02 2006 0950 ENRICO /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-17-1919 9. Birthplace (State or Foreign Sex M 2□ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. 578-12-0877 86 Washington, Director Usual Residence of Decedent 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland | Prince George's Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 9010 Briarcroft Ln. USA deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXXVo ģ 3 Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Car Repairman Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill timent of Health and Mental H tant: If Item 27 is marked other Fiorovante DiPietro Mary Bellafatto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 7171 Mason Dr., Chincoteague Island, VA 23336 Mary F. DiPietro/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 5-5-06 Kalas Crematory Edgewater, MD 4 Donation 5 🗆 In er (Specify) 21. Signatur of Funds Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) in Resertons SE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a Box 68760. Completed by Physician/Medical been signed by the ettending should be detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | NO 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1∐ Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one 20 No Cthen 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral L completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of qertifi eted cause of death (Item 23a) (Type, Print) EXENSE HIGHWAY 31. Date filed (Month, Day, Year)

State

. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Amended Item 20b per F.D. 05/04/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 2, Physician Year Charles Francis Ecker Jr 2006 8:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year II Under 24 Hrs. B. Date of Birth (Months Days Hours Min. (Month, Day, Year) April 26, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral XX**M 2□ F 87 220-03-1915 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23e or 28e-1 show sny injury or other traumatic event, I'm Medical Examinar manner. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21791 13746 New Windsor Road United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:

WW.II. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 service business oil business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adelaide Schnobel Charles Francis Ecker, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13746 New Windsor Road Union Bridge, MD 21791 Mildred Ecker Wife 20b. Place of Disposition (Name of Lakemy Person Mairon 1 a To Pare) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Cemetery 4 ☐ Degation 5 ☐ Other (Specify) Sykesville, M 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory,
1212 W. Old Liberty Road Winfield, MD 21. Signature of Funeral Service Lice e, Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause in each line. Interval Between Onset and Death mmediate Cause (Final r condition resulting in death) Prostate (ancer Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? autopsy performed2 2 No 1 Yes 2 No After this certification 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No iours after death.
nere! Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 00055793 IOTIVA 5/2/06 400 WEST 7th STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Memorial Hospital FREDERICK, MD 21701 ouresh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear **Physician** 3, 2006 12:30AM May Joseph Emmett Foley, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 344 Broadview Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 3, Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours Yrs. 1936 70 Feb. Massachusetts 013-28-3760 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Annapolis Mary land 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or itams 23a or 21401 United States 344 Broadview Lane death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 195 If Yes, Give Year or Dates: 195 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1958 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1959 natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Telecommunications Engineer Pages 1 and 2 should be filed vent of Health and Mental Hygis int: If Itam 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Mary McGuire Joseph Emmett Foley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Maryland 21401 Mary Joan Foley / Wife 344 Broadview Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ₩ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State ö permit. Page Department of Important: If any injury or once. Crownsville Vet. Cem. 5/10/ 2006 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Ligensee 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final CUNCER **Physician** disease or condition resulting in death) 1419 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the ald d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part f. Completed by 1 Yes 2 No 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ № 24a. Was an page 2 s certificete 1 Yes 2 No To the Hospital or Attending Physician: illed in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fittle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 MM 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 0 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** A M May 5 Kennita LOU Fraley 2006 3:17 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Memorial Hospital Frederick Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 8-15-1960 **Funeral** Months 1 M 2 XF 45 215-78-3107 Yrs Pennsylvania Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be rullified at MD 1 ☐ Yes 2 XNo Frederick THurmont Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 7103 Kelly's Store Road 21788 U.S.A. death 1 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status fited within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Account Manager Mortgage Corp. marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if item 27 is marked othe any njury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth J. Kenney Patsy Irene Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. Fraley (Husband) 7103 Kelly's Store Rd. THurmont, Md. 21788 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5/06/06 Smithsburg, Md. 21. Signature of Puppiral Service Licensee 22. Name and Address of Facility ROBERT E. DAILEY & ERT E. DAILEY & SON FUNERAL HOMES, P.A. E. Main Street Thurmont, Md. 21788 23a. Part1. Ever the disease, or complica shock or heart failure. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician therosclerotic /Medical Due to (or as a consequence of) Examiner Due to (or as | consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Year Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy 2 X No 20 No this certificate 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No director 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ို 2 ER/Outpatient 3 DOA : After thi 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 23s Cattlet (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number se of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) MAY 0 8 Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Hazel Grav 1:50 P M Apr 28, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Sunderland Calvert 1044 Claggett Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 27, 1924 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🗶 F 213-46-6971 81 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itama 23a or 28a-f show ery Injury or other traumatic event, Ira Maryland Examination. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Sunderland 1 Yes 2 No Director MD Calvert 10e Street and Number 10f Zip Code 10g Citizen of What Country? 20689 U.S.A 1044 Claggett Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. I ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) **Domestic** Someone Else's Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pricilla Brown **Eugene James Wills** ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6032 Stephen Reid Road Huntingtown, MD 20639 Roberta Giles/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05/04/06 Chesapeake Beach, MD Ernestine Jones Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Sewell Funeral Home 21. Signature of Funeral Service Licenses Blader 1451 Dares Beach Road Prince Frederick, MD 20678 a-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 🗷 No 1 🗀 Yes 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death? Jas certificate 2 🗆 No 1 Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referre medical Be 26. Place of Death Check only examiner? Other 4 Nursing Home 5 PResidence 6 Other (Specify) 2 VNo 1 Yes Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No М investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 017168 Summerel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huntingtown, MD 6 2 dani

State Registrar Kloumarce

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

32. Registras Signature

2005

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			State of Marylar	nd / Depa		ealth and N	Mental Hygi	ene g. No2 () ()	6 15866
Physic		Decedent's Name (First, Middle, Last) Jeanne Caro	ol Gore				2. Date of Death		aar 3. Time of Death 1832 M
/Med Exam		4a. Facility Name (If not institution give st DOR CHESTER SEN	VERAL HOST	PITAL	4b. City, Town, or Am	BRID (SE	4c. County of DORC	NESTER
Funera Directo		5. Social Security Number 6. Sex	7. Age (<i>in yr</i> s. 79 79 79 79 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 1,	1926	Birthplace (State or Foreign West Virginia
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	by Funeral		2. Was Decedent Ever in U Armed Forces? 1 Yes, 22 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba		pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race -	American Indian, White, etc. White
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Diving the Hospitel or At within 24 hours effer of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the till vestigation, in my o	me, date and place ppinion, death occu	, and due to the ca rred at the time, da	use(s) and mann te and place, and	ner as stated. d due to the cause(s)
To the within 2 To the complet	₩ W	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Month, Day, Year)
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		30. Name and address of person who co		em 23a) (Type,	St. Ca	mbridg	e MD	2161	3
	State strar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	hood	0	7		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Rosemary Christine Grav May 5, 2006 3:30 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 11211 Country Road Dunkirk Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 15, 1927 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 111-20-8935 1 ☐ M 2 🕱 F 78 Yrs Director New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at MDCompleted by Funeral Director Calvert Dunkirk 1 ☐ Yes 2 ☑ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11211 Country Road or Items 23a 29754 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced Specify "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na eny Injury or other traumatic event, Itte Madic 2008. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patrick William Gavigan Charlotte Palen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Tyner (daughter) 11211 Country Road Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) May De 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2006 Brentwood, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee Cary J. 8125 Southern Maryland Blvd. Goff Owings, MD 23a. Aart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Encl 5+age
Due to (or as a consequence of): Renal disease /Medical Examiner Cardio vasculas ditease pertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by elfucion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Horombosic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. neral Director; A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after Fo the Funeral Direct 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29c. License number D 50653 0 29b. Signature and-title of certifier 29d. Date signed (Month, Day, Year) -ana, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAIY - C SCIRANA 5851 - Deale Church ten Road Deale MD 32. Registre's Signature 31. Date filed (Month, Day, Year) Registrar 8 2006

DHMH 17 Rev 1/2001

Security of Death 3825 Dogwood Road Specific Number S. Social Security Number S.				1 - For Stata Registrer	State of Ma	aryland / Dep <i>Ce</i>	artment of F			ene	15868
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The state of the s		೬೦೯ ಕರ		1004	\$	\$12	25 Southe	rn Maryla	nd Blvd.,	Owings,	MD 20736
Due to (or as a consequence of): The part of the pa		/Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence (f):					Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	K 68/60,	erificate be execute ling physician and e as the burial-trans	dical	resulting in death) Last	_ d.						
25. Was case referred to medical examiner? 1	.O. BO	the death or y the attend iched for us	ysician/	23b. Was decedent pregnant in the past 12 months? 1 \(\subsection \text{Yes} 2 \subsection \text{No} \)	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3					*
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\bigcirc	Maryland -f show lied at	_	10a. State 10b. County	100.	City, Town or Lo	ocation					10d. Inside City Limits
	the Ma	cto	MD Dorch	ester	Cam	bride	ge		_		1 ☐ Yes 2 ☐ Mo
Q	or 2	by Funeral Director	10e. Street and Number	. 1		10f. Zip Code	,		10g. Citi	izen of What Cou	untry?
2	death with ms 23a or	ie i	5404 Cast	le Havien	Road	. 21	613		1 2	15A	
0	ems	Inel	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of	f Hispanic Origin? uban, Mexican, Pu	(Specify Yes or N	0-	14. Race - Amer	ican Indian,
9	or it	正	1 ☐ Never Married 2 Married	1 Yes 2 No /	19.	1 ☐ Yes 2 ☑ N		sito riloan, etc.)		Black, White	
215-0036	within 72 hours after ene. than "natural", or ite	d b	3 Widowed 4 Divorced	Year or Dates:	763	10163 21219	о зресну.			Specify: Bla	ICK
2	72 h	ete	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occ	upation	rorkina	16b. Ki	nd of Business/Ir	ndustry
7	ithin	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	/ife.	^ ;	ne during most of w red)	orning .	1		21
S	filed w Hygier thar ti	Completed		5+		ast	Or		14,	M, E, (hurch
nd	be fill ta! H d oth	Be	17. Father's Name (First, Middle, Last				18. Mother's N	ame (First, Middle	a, Maiden	Sumame)	
<u>ya</u>	2 should be filed within and Mental Hygiene. Is marked othar than aumatic evant, the Mental Burnatic e	2	Willian	n Hall			One	v Ful	ler		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be rutified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	et and Number or I	ural Route Numi	er, City or	r Town, State, Zi	p Code)
_	1 and Health am 27 thar tr		Theonia	Hall	590	4 Cast	le Have	n Bd. C	anh	ridge.	MD. 21613
ore	of H of H fitar		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		. Place of Dispo cemetery, cren	sition (Name of natory or other p	lace)	Date		cation - City T	own, State
<u>Ē</u>	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar to once.		4 □ Donation 5 □ Other (Special		hapel	Comote	5/	20/06	Ea	STANN	laryland
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licer	nsee		The second second second	res of Facility	1 11.440	PA.	10.7	14141411
Ω	Depa Impo any ir		Janelle 1	M. Servis	H_{5}	DING SI	rest of Facility - UNERA	St. Can	المطا	Ja = 110	21613
			23a. Part. Enter the disease, or com sheck, or heart failure. List only	plications that caused the de	ath. Do not enti	er the mode of d	ying, such as cardi	ac or respiratory	arrest,	ag chino	Approximate
	nysician		Immediate Cause (Final	0	: H	Preum					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	(d') 12	1 near	au >				
E	Examiner			Pulmonery	Pimo	Ril					
		ē	Sequentially list conditions,	b. Due to for es a cogs	and the same of th			-		-	
1	ured d ansit	Examiner	flany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Multile	orcer	Faile	We				
٠.	n an ial-tr	Exa	resulting in death) Last	Due to (or as a cons	equence f):						
1092	incate be executed physician and as the burial-transit	cai		, Acute +	1 + o cara	62l 16	for her				
68	phy as the	edic			Ŧ		U				
Вох	attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	nancy				2	3d. Date of delive	on.
Ď	a atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnant Other (specify)	су		-	Month	Day Year
0	by the tached	Jysi	9 Unknown	9□ Unknown							
۵.	ine raw requires that the death certification has been signed by the attending phy agge 2 should be detached for use as the		Part II. Other significant conditions of	contributing to death but not re	esulting in the un	nderlying cause g	iven in Part I.	23e. Did	obacco us	se contribute to the	he cause of death?
Records,	lures Sign	d by						1 🗆	Yes 2.2	Š No 3 □ Prob	pably 4 Unknown
000	been si should I	Completed						04- 146-			
Re	cate has	Ę.						24a. Was		prior to condeath?	psy findings available mpletion of cause of
								1 ☐ Yes	2) € No	1 Yes	2)KIN0
Vital	this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			thon	eath (Check only			
-	this raidi	2	1 ☐ Yes 2 ☐ Death	1 Ampatient 2 28a. Date of Injury	ER/Outpatient	3U DOA	4 U Nursing	Home 5 Resi			y)
E 5	After fune	ioi	1 Natural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe	now injury	occurred	
Sign	death tor: the	ical	2 Accident investigation 3 Suicide 6 Could not be		hama farra at a		Yes 2 No	001.1	-		
Division	after Dirac in by	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)	et, factory, office)	City or To	street and vn, State)	Number or Rura	I Route Number,
-	aral		One Comities and Comities with					<u> </u>			
9	villan 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Check only one) 1 Certifying Ph 2 Medical Exan	nysician: To the best of my kininer: On the basis of examin	nowledge, death nation and/or inv	occurred at the t estigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) a date and (ind manner as st place, and due to	tated. the cause(s)
t d	within 2.	Mec	29b. Signature and title of gertifie	and manner stated.			se number				
ř	₩ ₩ ₩ 8		Mad A	7 MO		250. Elcen	and the state of			signed (Month, i	Day, real)
		194	Vol	7		104	1924		3.	3-06	
			30. Name and address of person who	_	_			A	2		
12.	8		NOMAN THANG 31. Date filed (Month, Day, Year)			CAM	DR IDGE	1911	116	0/3	
	Sta Registr		MAY 0 8	32. Projetrar's Sign	Ialuf8	hads					
5	agiaii	***	MAN A C		10 M	-					

06-03063 Timothy W. Harris

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Dea		Re	eg. No. 200	6 1587
Physician Medical Examine	4	1. Decedent's Name (First, Middle,Last) Timothy Wood Harris		2. Date of Deat Month May 6, 200	Day Year	3. Time of Death 0343 hrs
			, Town, or Location of Deat		4c. County of Death	
Funeral	7		der 1 Year If Under 24Hr	s. 8. Date of Birl	th(MM/DD/YYYY) 9. Birt	
Director		212-66-0128 1xm 2 F 50 Yrs. Mont	ths Days Hours Mir	Sept.	10, 1955 Co.	n untry) MD
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	<u> </u>			10d Inside City Limits
ne Maryland or 28a-f show any fied at once.	<u>.</u>		ambridge			1 Yes 2 X No
	Director	10e. Street and Number 10f. Zi 5520 Sand Road	ip Code 21613	10	og. Citizen of What Coun	try?
r death with th	- L		dent of Hispanic Origin? (S cify Cuban, Mexican, Puerto			can Indian, Black,
ter deat		3 Widowed 4 Divorced If Yes, Give Year	2 X No specify:	rican, etc.)		ite
5-0036 ed within 72 hours afte tygiene than "natural", the Medical Examiner	6 - 6	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usua during most of we	al Occupation (Give kind of orking life. DO NOT use ret		16b. Kind of Business/In	ndustry
thin 72 ne than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	minator	52)	pest cont	rol
filed with Hygier d other with Mygier		17. Father's Name (First, Middle, Last)	18.Mother's Name			
ID 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medica	0 20	Daniel S. Harris Jr. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Addres	Ruby Street and Number or		ber, City or Town, State,	Zip Code)
Baltimore, MD Permit Pages I and 2 sho Department of Health and Department of Health and Important: If item 27 is injury or other traumati		Regina Harris wife 5520 Sa	nd Road, Cam	bridge,	MD 21613	
Baltimore, M permit Pages I and 2 Department of Health Important: I'tien 2 injury or other traun		1 Burial 2 X Cremation 3 Removal from State crematory or other place	e)	Date	20c. Location - City or 7	
Baltimo permit Pag Department Important: injury or ot	ŀ	4 Donation 5 Other Specify Salisbury Cres 21. Signal are of Funeral Service Licensee 22. Name and	matory 5 d Address of Facility T	/6/06 homas Fu	Salisbury neral Home	, MD P.A.
យ ឱភ្និ≣្ Physician	+		ocust St., Ca	ambridge	, MD 21613	
/Medical		fallure. List only one cause on each line. Immediate Cause (Final disease a Narcotic (Methadone) intoxicat		or respiratory arre	st, shock, of flear	Approximate Interval Between Onset and Death
Xaiiiiiei		or condition resulting in death) Due to (or as a consequence of):				_
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
gi.	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
execu an and al - tra		x unpended Amended item#23a,27,28a-f,g857	7,7/5/06 TT			
760, ficate be sphysical the burn	۶	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Box 68' e death certiff the attending ed for use as	rnysician	past 12 months?		ancy	Month Da	ay Year
Division of Vital Records, P.O. Box 68' for the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as policical Cortification: To Bo Completed by Divesivian		1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I	23e. Did tob	pacco use contribute to the	ne cause of death?
s, P.O. B nires that the d signed by the d be detached	3				2 No 3 Proba	
Records, The law requires ficate has been sig page 2 should be	bier		<u> </u>	24a. Was a autops perform	y prior to co	ppsy findings available mpletion of cause of
ital Records, ician: The law requires s certificate has been s rector, page 2 should		25. Was case referred to medical	26.Place of Death (Check	1 🗸 Yes 2		2 No
f Vita Physicia er this ce ral direct	2	1 63 2 100	DOA Other Nursin	ng Home 5 F	Residence 6 Other:	
on of \nding Ph. tth r: After th be funeral		27. Manner of Death 1 Natural 5 Pending S/6/2006 28a. Date of Injury (Month, Day, Year) 5/6/2006 3:43 am	28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred	
Division or spiral or Attending to bours after death neral Director: After filled in by the fune for the forest or	3	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory	**	28f. Location (St	reet and Number or Rura	Route Number, City
Divisior Hospital or Attence 24 hours after death Funeral Director: tely filled in by the		4 Homicide determined (Specify) Residence at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	o time, data and place are		5520 Sands R	
To the Hospital within 24 hours To the Funeral completely filled		one) 2 Medical Examiner: On the basis of examination and/or investigation, in m and manner stated				
2	≦	29b. Signature and title of certifier	O.C.M.E.		29d. Date signed (Monti	h, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)			May 7, 2006	
			eet, Baltimore, MD 2	1201		
Stat Registra	-	31. Date filed (Month, Day, Year) MAY 1 1 2006 32 Hegistrar's Signature	<u> </u>			
DHMH 17 Rev 1/2001	1	ORIGINAL				

			1 - For State Registrar	State of M	Maryland / Depa	artment of He			ene g. No2 0 0 6	15971
			Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physic		John Paul He	ring				May 1,	2006	
	/Medi Examir		4a. Facility Name (If not institution,		nr)	4b. City, Town, or Lo	ocation of Death	1111/11/	4c. County of Dea	
			Carroll Lutheran	Village H	ealth Care	Westmin	nster		Carro1	1
	Funeral			5. Sex 7. /	Age (In yrs. last birthday)	If Under 1 Year	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign country)
	Director		218-32-0745	1 X M 2□F	81 Yrs.	Months Days	nours Min.	Sept 10		aryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		-		
	Aaryli r sho	ō	_		ison only, rount of Ec	oution.				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the h	Director	Maryland Carro	11		10f. Zip Code	Westmins		- 0111	
	With Ba or							10	g. Citizen of What C	ountry?
	death ms 2	Funeral	984 Beggs Ro	12. Was Deceder	nt Ever in U.S. 13.	21157 Was Decedent of Hisps	anic Origin? (Spe	city Yes or No-	USA 14. Race - Am	erican Indian
ယ္	after or Itel	F	1 ☐ Never Married 2 X Marrie		32No	Was Decedent of Hispa If Yes, specify Cuban,	Mexican, Puerto I	Rican, etc.)	Black, Whi	
<u>Ö</u>	ral', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates		1 ☐ Yes 2 🗽 No 🥴	Specify:		Specify:	White
5-0	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ant, I're Medical Evarifrer must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupation kind of work done duri	on	1	6b. Kind of Business	/Industry
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4o	lite	DO NOT use retired)	ing most or workii	ng		
2	led w lygier her th		12	0	Fan					Acres Farm
and	be fill tal H od otl	Be	17. Father's Name (First, Middle, La			18	3. Mother's Name	(First, Middle, M.	aiden Sumame)	
$\frac{8}{5}$	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ILE ME	ဥ	Francis F. He					t E. Gre		
Ma	iges 1 and 2 should be filed within 72 hours after death with the Marylan at of Heath and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Medical Evant		19a. Informant's Name/Relationshi Barbara Hering	Wife		ng Address (Street and				Zip Code)
e,	es 1 and 2 of Health item 27		20a. Method of Disposition	MTTE	20b. Place of Dispo	Beggs Rd.	-	inster,		T- 0
00	Pages nent of H ant: If ite ury or of		1 Burial 2 Cremation 3		e cemetery, cren	natory or other place)	I I	. 12	Oc. Location - City or	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		` 4 □Donation 5 □ Other (Special Service Li	• ·		Cremation 3		/06 H	ampstead,	Maryland
Ba	permit. Departr Imports any inju		Jel V A		Pi	Name and Address of Ltts Funer	al Home	and Char	pel, P.A.	
			23a. Part. Enter the disease, or or	omplications that cause	ed the death. Do not enti-	2 Washingt	on Road	Westmi	nster, MD	21157 Approximate
			shock, or heart failure. List or Immediate Cause (Final	nly one cause on each	line.		1000		.,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	s a consequence of):	atosis -	TNASL	U3112		Hvesks
Н	Examiner				s a consequence of).					
	146	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter onderlying Cause (Disease or injury	b. Due to (or a	s a consequence of):					
	cuted nd ransil	Examiner	that initiated events	с.						
oʻ	e exe ian ai urial-1	Ë	resulting in death) Last		s a consequence of):					
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d.						
9	entific ling p	Mec	IF FEMALE:			_				
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			23d. Date of del	•
O	at the de by the a tached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of death 5	Other (specify)			Month	Day Year
۵.	that ti	Ph	Part II. Other significant conditions	s contributing to death	but not resulting in the un	darhing causa gwan ir	n Post i	23a Did tahar	200 Line contribute to	the serves of death 0
ecords,	w requires that been signed b should be deta	d by		coasitive	HWF Fzi	we /	iiraiti.	1 ☐ Yes	cco use contribute to 2 No 3 Pro	obably 4 DUnknown
Ö	w req	lete	-) ,				· ·		
Ř	The lavate has	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vital		မ Co	25 Man ages referred to market					1 Yes 2€	No 1 ☐ Yes	2 🗆 No
5	s cert	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	A	Othor	3. Place of Death			~
ō	Phys er this eral di	H	27. Manner of Death	28a. Date of Inj	urv 28b. Time of	3 DOA		e 5 ☐ Residend 3d. Describe how	e 6 □Other (Spec	oify)
<u>0</u>	nding P th. : After I	tloi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ay Year) Injury	28c. Injury at Work? M 1 ☐ Yes	2 □ No		mjary cocarred	
DIVISION	Attender deatle ector:	iflos	3 Suicide 6 Could not	28e. Place of in	jury - At home, farm, stre	et, factory, office	28	3f. Location (Stree	et and Number or Ru	ral Route Number
ב	s afte	Certification:	4 FORNICIDE	building, e	tc. (Specify)			City or Town, S	State)	
	ospit hour unera ly fille		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge, death	occurred at the time, d	date and place, an	nd due to the caus	e(s) and manner as	stated.
	or the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	one)	aminer: On the basis of and manner s	of examination and/or inv	estigation, in my opinio	on, death occurred	at the time, date	and place, and due	to the cause(s)
	To To t	Σ	29b. Signature and title of certifier	(mel 1		29c. License nui	mber	29d.	Date signed (Month	, Day, Year)
	10154		X	The !	Y	1000	39943	1	13y 2,2	020
	M210		30. Name and address of person wh		death (Item 23a) (Type, F	rint)			-	
	-		John (. Anolimo	295 Stan	er Are. Suit	e 301 v	restmins	ter Wi	2115)	
	Stat Registra		31. Date filed (Month, Day, Year)		rar's Signature	,		12-1		
	11091311		MAI U J	ZUUD A	en & A	mark 1				

			For State Registrar	State	of Maryla		artment of H		Mental Hy	giene	'HHI	15872			
4	· .	S.	1. Decedent's Name (First, Middle						2. Date of De	aath Day	Year	3. Time of Death			
	Physicia /Medic					Harring			April	29	2006	4:00 P M			
	Examin	er	4a. Facility Name (If not institution		number)		4b. City, Town, or			4c.	County of Death				
			Vindobona Nurs	ing Home	7 Age (In vrs	. last birthday)	Braddo	ck Heigh	S. 8 Date of Bi	rth	Frederi	Delace (State or Foreign			
	Funeral Director		578-22-1774	1 ☐ M 2 🔀 F	82	Yrs.	Months Days	Hours Mir	May 5	ay, Year)	Cou	nswick, MD			
	D		Usual Residence of Decedent						Thay 5						
	how		10a. State 10b. County		10c. C	ity, Town or Lo						10d. Inside City Limits			
	Ba-f e	cto		erick		Jeffers						1 ☐ Yes 2 🗓 No			
	vith th	DIE	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou USA	untry?			
	death with the Maryland me 23a or 28a-f show	Funeral Director	2024 Virts Lane		ecedent Ever in	115 13 1	Jeffer		Specify Ves or No) ·	14. Race - Amer	ican Indian			
	iter di	E.	1 Never Married 2 Marr	Armed	Forces? s 2 13(No	0.0.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		Black, White	, etc.			
000	urs a	þ	3 Widowed 4 Divorced	If Yes, (Year of	Give		1☐ Yes 21X No	Specify:			Specify: Wh	ite			
2	72 ho	Completed	15. Decedent (Specify only highes		d)	16a. Deced	dent's Usual Occupa	ation during most of we	orkina	16b. Kir	nd of Business/l	ndustry			
V	ithin 36.	du	Elementary/Secondary (0-12)	T	(1-4or 5+)		kind of work done of DO NOT use retired)		Ша	memaker				
7	lled w tygier her ti		12 17. Father's Name (First, Middle,	l acti		Hous	sewife	18 Mother's Na	me (First, Middle						
ala	ntal F ed of ed ot	Be	Ira Irvin Bohr	,					Regina C		,				
2	thouk Id Me mark matic	ဥ	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street a					ip Code)			
Z Z	od 2 s Ith ar 27 ie r trau		B. R. Harringto		and		Virts La				21755	,			
<u>5</u>	f Hea f Hea item othe		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of natory or other place		Date		cation - City or 1	own, State			
Ē	Page ient o int: if iry or		1 XBurial 2 ☐ Cremation 4 ☐ Dogation 5 ☑ Other (Si		m State Pa		ghts Ceme	_	/3/2006	Brun	nswick,	MD			
Saitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: if time 27 is marked other then "natural; or iteme 25 a or 28a-f show eny injury or other traumatic event, tra Medical Examinar must be notified at once.		21. Signature of Funeral Service	Home											
	402.0		John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
			shock, or heart failure. List	only one cause or	each line.	0		g, such as cardie	ic or respiratory a	11631,		Approximate Interval Between Onset and Death			
Ţ	Physician /Medical		disease or condition resulting in death)	d	OLON		CER					3 MONTHS			
	Examiner			Due	o (or as a conse	querice or).									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due t	o (or as a conse	quence of):									
	cuted nd ranslt	Examiner	that initiated events	с			<u>-</u>								
<u> </u>	e exe	I Ex	resulting in death) Last	Due t	o (or as a conse	quence of):									
00/0	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d											
Ď	entific ding p		IF FEMALE:	23c If yes	outcome of pregr	2004									
מסמ	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3	Ectopic pregnancy Other (specify)			2	3d. Date of deliving Month	ory Day Year			
j	the di y the ched	ysle	1 □ Yes 2 □ No 9 □ Unknown	e □ Uni		404	Garan (speeny)								
Ţ	s that		Part II. Other significant condition		death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did 1	obacco us	se contribute to	the cause of death?			
records,	quires n sign	ed by	MZHEM	ers Di	ement i	+			1 🗆	Yes 2	No 3□ Pro	bably 4 ∐Unknown			
္သ	aw re	plet							24a. Was		24b. Were aut	opsy findings available ompletion of cause of			
ř	The i	Completed		_					auto perfo	rmed?	death?				
VII	sian: artific ctor,	Be (25. Was case referred to medical examiner?						ath (Check only o	опе)					
>	hysic this ca	은	1 ☐ Yes 25 No			ER/Outpatien		4 Nursing	Home 5 Resi			fy)			
	After	on:	27. Manner of Death 1 Vatural 5 Pendin	g (Mo	te of Injury onth, Day Year)	28b. Time of Injury	Work	at ? /es 2 □ No	28d. Describe	how injury	occurred				
DIVISION OF	deeth deeth stor: , the	cat	2 Accident investig	ot be 290 Pla	ce of Injury - At I	nome farm str	eet, factory, office	165 Z NO	28f Location (Street and	d Number or Rur	al Route Number,			
2	al or A s effer i Dire	Certification:	4 Homicide determ	bui	lding, etc. (Spec	ify)	out, radially, diffic		City or To						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours elater death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	he best of my kn basis of examin anner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)			
	To the Within To the Complete	Me	29b. Signature and title of certifier				29c. License				signed (Month,				
)	Ulle	- F	W	1)	16675		M	MO1,	2006			
	10		30. Name and address of person	who completed ca	use of death (Ite	3a) (Type,	Print)		21716		•				
			31. Date filed (Month, Day, Year)	LLGATE	Party Sin	UKUN	5 WICK	v (I)							
	Sta Registr		MAY 0 3	2006	Pagistrar's Sign	& A	mess)								

			1 - For State of Maryland / Registrar		artment of H			jiene	15873					
T A	\$ E :		Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death					
36.00	Physic /Medi		STEPHEN E. JARRETT				MAY 04	Day Yes	8:11 A M					
	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De		4c. County of D						
			809 LONG WHARF ROAD		SAL	ISBURY		WIC	OMICO					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 H	in. (Month. Day	, Year)	Birthplace (State or Foreign Country)					
	Director		218-50-2095 X S S S S S S S S S S S S S S S S S S	Yrs.			09-23-1	953 PEN	NSYĹVANIS					
	/land		10a. State 10b. County 10c. City, To	wn or Lo	cation				10d. Inside City Limits					
	the Marylan 28a-f ehow	ţō	MD WICOMICO SALI	SBU:	RY				1 ☐ Yes 2√2 No					
	or 28.	lrec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?					
	23a c	Funeral Director	809 LONG WHARF ROAD			21804		U	SA					
	sep se	Tuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of His	spanic Origin?	(Specify Yes or No- erto Rican, etc.)		merican Indian,					
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		☐ Yes ※☐ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:						
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show sdigs! Examinar must be notified at	ed b		Dece	ent's Usual Occupa	ina			WHITE					
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217	filed within Hygiene. ther than "	E	Elementary/Secondary (0·12) College (1·4or 5+) 12 4	PLAN	T MANAGER			POUL	TRV					
	be filed ital Hygi od other	Bec	17. Father's Name (First, Middle, Last)			18. Mother's N	ame (First, Middle, A		IKI					
yla	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M	To	DILMUS JARRETT			ANN HA	RDING							
Maryland	2 sho						Rural Route Number,							
	ges 1 and 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehov or other traumatic event, the Madical Examinar mutal be confiled at					F ROAD,	SALISBUR	Y, MARYLA	ND 21804					
Baltimore,	Pages hent of Hunt: If Ite		1 ☐ Burial 25 ☐ Cremation 3 ☐ Removal from State	ery, cren	sition (Name of natory or other place			20c. Location - City						
Ħ			4 Donation 5 Other (Specify) 21. Signature of Juperal Service Licensee	4 □Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 05-05-2006										
Ba	permit. Departr Importa eny inji		Alalisa Abasela Rha ka	7.0	Name and Address	of FacilityBO	UNDS FUNE	RAL HOME,	INC.					
			23a. Part1. Enter the disease, or complications that caused the death. Do	not ente	The mode of dving	AIN SIR	EET, SALISI	BURY, MAR	YLAND 21804 Approximate					
	Physician		Immediate Cause (Final	0	1		_	731,	Interval Between Onset and Death					
	Physician /Medical	Q I	disease or condition resulting in death) Due to (or as a consequence	100	eny	Cano	en							
	Examiner	į.		101).										
(=	7 -	ner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):										
	ecute and transi	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last											
60,	cate be executed obysicien and the burial-transit	Ē	Due to (or as a consequence	of):										
8760,	phy:	dicai	d			_								
×	eath certifii attending p for use as	0	IF FEMALE: 23c. If yes, outcome of pregnancy											
Вох	the death certifi y the attending iched for use as	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year					
0	that the de led by the a detached i	ıysi	1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown	J _	Ottier (specify)									
ď.	The law requires that ite has been signed b page 2 should be deta	by PI	Part II. Other significant conditions contributing to death but not resulting it	in the un	derlying cause given	in Part I.	23e. Did tob	acco use contribute	to the cause of death?					
Vital Records,	w require been sig should b						1 □ Yes	s 2 <mark>2</mark> No 3□1	Probably 4 Unknown					
000	aw requisite parameter speeds	Completed					24a. Was an	24b. Were	autopsy findings available					
ž	The lav	E O					autopsy	prior to death?	completion of cause of					
ita	certifica ector, p	Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one	No 1 Ye	5 21 10					
of <	dis dis	0	1 Yes 25 No Hospital: 1 Inpatient 2 ER/Ou	utpatient	Cthan		¥	nce 6 Other (Sp	ecify)					
n		on:		Time of Injury	28c. Injury a Work?	t	28d. Describe how	w injury occurred						
Division	tan leatl lor: the	icat	2 Accident investigation 3 Suicide 6 Could not be			s 2 No								
=	P trice	Certification:	4 Homicide 4 Homicide 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,					
_	Hospital or 14 hours afte Funeral Dir tely filled in		29a. Certifier (Check only Check only Medical Symptotic Co. No. 1) Medical Symptotic Co. No. 1) Medical Symptotic Co. No. 1)	a doath	accurred at the time	data and -1								
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	(Check only one) Medical Examiner: On the basis of examination an and manner stated.	d/or inve	estigation, in my opin	ion, death occ	urred at the time, dat	te and place, and du	e to the cause(s)					
	To the Hospital within 24 hours a within 24 hours a To the Funeral Completely filled it	Me	295. Signature and title of certifier		29c. License r	umber	290	d. Date signed (Mor	ith, Day, Year)					
}		4	WUZKI, MD		DA	627	8	5-4-0	36					
-2	5 inf		30. Name and address of person who completed cause of death (Item 23a)	(Туре, Р	rint)		- C	1)	(A)					
1	[11]		Heufloisall, MD Coastal Hospin	~	10 3	0x/73	5 00%	ish, K	e to the cause(s) ith, Day, Year) 2 L 3 7 80 —					
	Sta Registra		31. Date filed (Month, Day, Year) 32. Figistrar's Signature	A	act 1	-		0						
2 20	riegisti	21	2000	100										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Yea ernidan 6.10 A M TOVEDIO 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8799 Hickory Hill Walkersville Under 1 Year | If Under 24 Hrs. Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Months Year) 1 □ M 2 KF Hours Min Director 217-42-4151 1910 Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1√2 Yes 2 □ No MD Frederick Walkersville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral [238 8799 Hickory Hill 21793 Pages 1 and 2 should be filed within 72 hours after death **USA** itema 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 *netural, or þ 1 ☐ Yes 2 1 No Specify. Specify: White 3 ∑Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Charlie Posev Parcell ပ Palie Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar important: if item 27 is any injury or other treu 8799 Hickory Hill - Walkersville, MD 21793 Gordon Jernigan - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Highland Memorial Gar 5/6/2006 4 ☐ Donation 5 ☐ Other (Specify) Ahoskie, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer Funeral Home Kohl M970 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Harpers Ferry, WV 25425 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ongestive /Medical Due to (or as\a consequence of) Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the et id be detached for 4□Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should s 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsv performe Yes 2 certificete of Vital Attanding Physician: Be director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ierel Diractor: After th 27. Manner of Death
1 Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 5 Pending death. М investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō

To the Hospitel within 24 hours at To the Funerel D

State Registrar

Medicai

29a, Certifier

29b, Signature an

31. Date filed (Month, Pay, 2006

title of certif

Name and address of person of mpleted cause of death (Item 23a) (Type, Print)

10

Solarex CX Frederick, MD 21703 610 uistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53986

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	Maryland / Dep Ce	ertificate of		•	giene	of the state of th	150	175
	Phone: -	E -	1. Decedent's Name (First, Middle	, Last)				2. Date of De	ath to U	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	3. Time of	Death
	Physici /Medi		Conrad W.	Judy				May 3,	2006	Year	6:22	АМ
2	Examir	ner	4a. Fecility Name (If not institution,		er)	4b. City, Town, o	or Location of Dea	ith	4c. Count	y of Death		
			205 Chestnut		Asset discussion in the state of		eville			n Anne		
	Funeral Director		5. Social Security Number 578–30–3856	6. Sex 7 1 1 M 2 □ F	Age (In yrs. last birthda) Yrs.	Months Days	Hours Mir	. (Month, Da	y, Year)	9. Birthpla Country	ce (State o	r Foreign
			Usuel Residence of Decedent		79 Yrs.			3-5-19	921	Conne	CTICU	.τ
	how		10a. State 10b. County		10c. City, Town or I	ocation.				100	d. Inside Ci	ty Limits
	Be-f	cto		Arundel	Ede	gewater					1	2 XNo
	with th	Director	10e. Street and Number			10f. Zip Code	27		10g. Citizen of		y?	
	eath v	era	1614 Oriole Ro		Tracia II C	210				SA		
,	fter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceder Armed Force ad 1 XYes 2	s?	. Was Decedent of F If Yes, specify Cub	lispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ce - Americar ck, White, etc		
9	af, o	by	3 ₩ Widowed 4 Divorced	If Yes Give	s: 1944–46	1 ☐ Yes 21X No	Specify:		Specia	y: Whi	te	
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2	vithin Pen	id m	Elementary/Secondary (0-12)	College (1-4o	or 5+)	DO NOT use retire	d)					
2	lied v Tygie ther t	ပိ	17. Father's Name (First, Middle, L	5+ year	cs Certi	fied Publ			Federa		rnmen	t
and	ould be filed v Mental Hygie arked other t attc event, to	Be	Jady C.					_{ime (First, Middle,} borah Rut				
2	shoul mark	ဥ	19a. Informant's Name/Relationsh		19b. Maii	ing Address (Street					odel	
	es 1 and 2 should b of Health and Menti fitem 27 is marked r other traumatic e		Conrad W. Judy,			Chestnut						
Je,	of Hei		20a. Method of Disposition		20b. Place of Disp			Date	20c. Location			
altimore,	Page nent c ant: If ary or		1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (Sp.			rematory	5-4	-06	Edgewat	ter, M	D	
a	permit. Pages 1 Depertment of H Important: If its eny Injury or ott		21. Signature of Funeral Service 2	icensee	2	2. Name and Addre	ss of Facility G	eorge P.		•		e
8	ZQ = 9 9		1 Want to	Wil -		2973 Solo			-	er, MD	2103	7
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause nly one cause on each	ed the death. Do not en line.	ter the mode of dyir	ng, such as cardia	c or respiratory ari	rest,	i in	pproximate	veen
1	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. Rif	RACTORY	ANsm	iA			0	nset and D	eath
H	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of)							
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	uted d ansit	Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,							
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õ	entifica ling pl	Med	IF FEMALE:					-				
ROX	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal death 3	⊒Ectopic pregnancy	,		23d. Dat	te of delivery	V.	ear
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant: 9□Unknown		Other (specify)			1010	our Da	iy 11	adi
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Hecords	quires n sign	g p	REDM IN	WE PIPIS	Jey			1 🗆 Y	_	3 Probabi		
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	hysician: The lav his certificete hes I director, page 2 :	E o		CELLI				autops perfori	ned?	prior to compli leath?	etion of car	use of
	strifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	1 ☐ Yes : ath (Check only on	4	☐ Yes 2	□ No	
> 0	Physician: this certific ral director,	2	1 Yes 2 No	Hospital: 1 ☐ Inpat	tient 2 ER/Outpatie	nt 3 DOA Othi		lome 5 ☐ Reside		er (Specify)	Son's	
	E E	ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury 28b. Time o lay Year) Injury	Worl	at c?	28d. Describe ho	w injury occurr	ed	Home	
DIVISION	Attending For death.	Cat	2 Accident investiga 3 Suicide 6 Could no	the -			Yes 2 □ No					
_	after after Direction by	Certification:	4 ☐ Homicide determin	ed 289. Flace of in building, e	njury - At home, farm, st. atc. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Numb n, State)	er o r Rura l Ro	oute Numbi	er,
	epita nours neral		29a. Certifier 1 X Certifying	Physician: To the bes	t of my knowledge, deat	h occurred at the tim	ne, date and place	and due to the co	ausa(s) and ma	nner as state	d	
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	one) 2 Medical Ex	taminer: On the basis and manner s	or examination and/or in	vestigation, in my or	pinion, death occu	irred at the time, di	ate and place, a	and due to the	e cause(s)	
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu	ž	29b. Signature and title of certifier	7		29c. License	number	2	9d. Date signed	(Month, Day	r, Year)	
				}	>	Da	3517	1	1 Ay 3	255)(0	
			30. Name and address of person was 139 Old Solomor	moleted c use of	death (Item 23a) (Type,	Print) Antho	ony M. C	aputo, M.	D.	~~~		
			31 Date filed (Month Day Vect)	is island R	trar's Signature	5, MD 2140	1					
	Sta Registra	ie ar	31. Date filed (Month, Day, Year) MAY 0 4	2006	trans Signature	and)						

			1 = For State Registrar	State of N	Maryland		artment of H rtificate of L			211	06	15876
54	1.2		Decedent's Name (First, Middle	ə, Last)			timoate or E	- Catir	2. Date of Dea	Reg. No:	V V	3. Time of Death
	Physici		Elester Mae	King					Month May	5 Day	006	10:55 a M
	/Medic Examir		4a. Facility Name (If not institution		or)		4b. City, Town, or	Location of Dea		4c. Count		10133 u
	and the second second		South River Hea	alth & Reha	bilitat	ion	Edgewa	ter		Anı	ne Ar	undel
	Funeral Director		5. Social Security Number 577–16–0172	6. Sex 1 ☐ M 2 ∑ F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, Year)	Cour	place (State or Foreign htry) D.C.
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Fown or Lo	cation				1	0d. Inside City Limits
	Mary 1 sho	ţō	MD Anne A	Arundel			Edgewa	ter				1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	
	238 c		144 Washington	n Road			2103	7		USA	A	
21215-0036	in 72 hours after death with the Maryland 1 "natural; or items 23a or 28a-f show tedical Examinatina the notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🎇 Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces ied 1 Yes 2 If Yes, Give 2 Year or Dates	s? XNo		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 💢 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, by: whi	etc.
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	be filed withintal Hygiene. Id other therevent, the Meren		12	t and		tele	egraph ope			wester		Lon
Maryland	ould be fi Mental H arked ot atic syst	Be.	17. Father's Name (First, Middle,	Hall				_	me (First, Middle,			1
Z	2 should by and Menta is marked sumatic so	은	James George 19a. Informant's Name/Relationsh			19h Mailir	g Address (Street a	Gertr			O'Neal	
Σ S	od 2 27 is		Patricia E. Vi		11.		Bayside					20732
ore,			20a. Method of Disposition		20b. Place	e of Dispo	sition (Name of natory or other place		Date	20c. Location -		
Ē	Pag ent nt: i		1 Burial 2 □ Cremation Donation 5 □ Other (Sp		Θ .	-	ans Cemete	´ l	10-2006	Chelter	ıham.	MD
Baltimore,	permit. Page Department o Important: if sny injury or once.		21. Signature of Funeral Service t	icensee R		22	. Name and Address	s of Facility			•	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. [Do not ent	Rausch Fur er the mode of dying	, such as cardia	ic or respiratory arr	est,	is, MI	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- Acut		reb	rovasu	ulær i	Acciden	nr	γ	Interval Between Onset and Death Mcyc Hay
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Division of Vital Records,	To the Hospitel or Attending Physicien: The I within 24 hours after death, To the Funerel Director: After this certificate he completely filled in by the funeral director, page	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investig.	28a. Date of Inj (Month, D	jury 28t	b. Time of Injury	28c. Injury : Work?	4 Nursing F	lome 5 Reside 28d. Describe ho			
Divis	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of Ir	njury - At home, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Sti City or Town	reet and Number, State)	er or Rural	Route Number,
	in 24 hour in 24 hour ha Funer pletely fill	edicai	29a. Certifier 1 Certifying (Check only one)	g Physician: To the bes examiner: On the basis and manner s	of examination	dge, death and/or inv	occurred at the time estigation, in my opin	, date and place nion, death occu	e, and due to the ca urred at the time, da	use(s) and ma ite and place, a	nner as sta and due to	ited. the cause(s)
	To t	Σ	29b. Signature and title of certifier				29c. License	A A S.	29	d. Date signed	3	
			rugin	C. V ~	- a	٠ .	D 5		5	5/5	,	006
			30. Name and address of person w	who completed cause of Deale (death (Item 23a			N -C		RAN		42 17
The state of the s	Sta	te	31. Date filed (Month, Day, Year)		tran Signature		un icc	DCI CX .	Deal	e n	10 -	20757
	Registra	100	MAY	- 8 200 6	General	K.	Cooles					

Amended Item 5 per F.D. 05/04/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. UUb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Howard Dale Loughry, Sr April 2006 3:30 рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 701 Glen Drive Westminster Carroll If Under 1 Year If Under 24 Hrs. 5.**234-526**4 N735 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Funeral Hours Days 1⊋M 2□F August 20 1920 234-26-1736 85 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Glen Drive 21157 USA 11. Maritat Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2□No WWII 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 2 Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Ruberoid Roofing Co/ Elementary/Secondary (0-12) College (1-4or 5+) Foreman GAF of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Loughry Rosa Lee Gower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Louise Reeb/daughter Westminster, MD 21157 701 Glen Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Gardens of Faith Cem | 05/05/2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts funerative and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hemorrha Gastrointestinal resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ Be Completed Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? (es 227 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Tes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital

the Maryland

hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Mar

burial-transit and

the attending physician the dor use as the buria

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page 2 s

certificate

After this certific funeral director,

death.

Baltimore, Maryland 21215-0036

r than "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at

within 24 hours after death To the Funeral Director: completely filled in by the MIL 10

Bionta 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier



.0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Ly . D

555 South Couter Street

29c. License number

D15552

29d. Date signed (Month, Dey, Year)

mel

21157

Westminster

				For Stete Registrar		State	of Maryla		artment o				g. No.2 ()	06	15879
		Physici		Decedent's Name (Fir Eleanor		st)		LUBIN				2. Date of Deat May 3,	2006	Year	3. Time of Death 5:30 A M
	, a	/Medio Examir	er	4a. Facility Name (If not Hebrew Home				ton		vn, or Loca Ckvil	ation of Death			y of Death	ry
		Funeral Director		5. Social Security Number 013-16-290	00 1	ex □ M 2∏ F	7. Age (In y 90	vrs. last birthday) Yrs.	If Under 1 Y Months D		Inder 24 Hrs. ours Min.	B. Date of Birth May 1 Day,	19 16		place (State or Foreign ntry) sachusetts
		Maryland Ited at	tor	Usual Residence of Dec 10a. State 10b DC	edent . County		10c.	City, Town or Lo Washingt	on, DC					1	0d. Inside City Limits 1X Yes 2 □ No
		th with the	al Direc	10e. Street and Number 5010 Nebras	ska Ave	., NW			10f. Zip Co 26	eb 0008		11	0g. Citizen of USA		ntry?
	036	rurs after deal al', or Itema : Examiner mu	by Funeral Director	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □		Armed F	2 ₹ No ive		Was Decedent If Yes, specify 1 ☐ Yes 2√2		ic Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
	21215-0036	within 72 ho lene. then "natur the Medical I	Completed	15. (Specify or Elementary/Secondary		ade completed)	(1-4or 5+)	(Give	dent's Usual O kind of work d DO NOT use re am Dire	one during etired)	most of worki	ing	Publi		
	Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First Louis SI	Middle, Last,					18. /		e (First, Middle, A e Nathan		me)	
	Mar	and 2 sho alth and 27 is ma		19a. Informant's Name/I		Type, Print) d aught	er		_			al Route Number, Washin	-		
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exam and must be notified at once.		20a. Method of Dispositi ↑♥ Burial 2 □ Crr 4 □ Donation 5 □ 21. Signature of Function	omation 3 on Other (Specif	y)	State S	b. Place of Dispo cemetery, crain haron Me	matory or other morial 2. Name and A	Park Park ddress of 1	May 5	, 2006		, MA w Fun	eral Home
LUBIN		Certificate be executed Additional Physician and Additional Additi	Ilcal Examiner	23a. Part1. Enter the dishock, or heart fail Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ure. List only	a. SEA Due to Due to	each line. JILE (or as a constitution of the					or respiratory arre		PE	Approximate Interval Between Onset and Death
NOR ,	O. Box 68	certific nding p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregin the past 12 mon' 1 ☐ Yes 2 MNo 9 ☐ Unknown			birth 2 ☐ F nant at time (etal death 3	Ectopic pregn Other (specif					ate of delive	ery Day Year
LEA	Records, P.	w requires been sign should be	þ	Part II. Other significant	CNT)		death but not	1	MS10	1	Part I.	23e. Did tob	s 200 No	3 🗌 Prob	
(77	/ital Re	ijci en : The lav certificate has rector, page 2	Be Completed	25. Was case referred to examiner?	o medical						Place of Death	autopsy	No No	death?	psy findings available inpletion of cause of
	Jo t	ding Phys J. After this (funeral dir	n; To	1 Yes 2 No 27. Manner of Death	70 "		Inpatient 2 of Injury oth, Day Year	2 ER/Outpatier 28b. Time o Injury		Other: Injury at Work?		me 5 Reside 28d. Describe ho			()
	Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	2 Accident	Pending investigation Could not be determined	e 28e. Place		At home, farm, str	М	1 🗌 Yes		28f. Location (Str City or Town	eet and Numi State)	ber or Rura	l Route Number,
	_	he Hospital n 24 hours he Funeral pletely filled	edical	29a. Certifier (Check only one)	Certifying Ph Medical Exer	niner: On the b	e best of my pasis of examiner stated.	knowledge, death nination and/or in	n occurred at the	ne time, da my opinion	ite and place, a , death occurre	and due to the ca ed at the time, da	use(s) and m te and place,	anner as st and due to	ated. the cause(s)
		To t Com	×	29b. Signature and title	of certifier	AC	un	nuo		01 St			d. Date signe		* .
		1		30. Name and address of	of person who	completed cau	se of death (Item 23a) (Type	Print) /2/ Ad	ONT	PASE	RO, R	SCRVI	US 1	1006 100832
	197	Sta	ite	31. Date filed (Month, D.	ay, Year)	32. 5	Red Istrar's Si	gnature.	Land)						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Richard Thomas Martin, II State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3 Time of Death Month Day May 12, 2006 1415 hrs **Medical Examiner** Richard Thomas Martin, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Prince George's Prince George Hospital Cheverly 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Washington DC Months Days Hours Min. 212-13-2010 Director 1 X M 2 F 35 May 15, 1970 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits any 10a. State 1 Yes 2 X No or 28a-f show MD Anne Arundel Lothian or items 23a or 28a-f shormust be notified at once. Director death with the Maryland 10e Street and Number 10f. Zip Code 10g, Citizen of What Country 20711 122 U.S.A. Α Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces' White, etc. 1 X Never Married 2 Married Yes 2 X No permit Pages I and 2 should be filed within 72 hours after Department of Health and Montal Hygiene Important: If item 27 is marked other than "natural", o injury or other transmatic event, the Medical Examiner: Yes, Give Year Widowed Divorce 1 Yes 2 X No specify: Specify: white \$ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 10 carpet installation technician flooring company 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Helen Richard Thomas Carol Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street, Lothian, Carol Martin, Mother MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore. crematory or other place) 1 X Burial 2 Cremation 3 Ressurection Cemetery 05-17-06 4 Donation 5 Clinton, MD Other Speaffy 21. Signature of Funeral Service Licensee 22. Name and Address of Facility elloals 20736 Rausch Funeral Home, P.A., Owings, MD he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on e Between Onset and /Medical Death Narcotic and phencyclidine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and /sician/Medical X UNPENDED X AMENDED item#1,4b,23a,27,28a-f,perME,G856,6/1/06 TI attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? page ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) To the Hospital or Attending Physician: Be Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred Natural Yes 2 X No 5 Pending Director: 5/12/2006 lunk 2 ____ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide or Town, State) unk determined (Specify) unk 4 To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) O.C.M.E May 13, 2006 ted cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	rytand		tificate of		-	gierie Reg. No.	006	15881
	Physici /Medic		Decedent's Name (First, Middle, L. William	Joseph	Mal	oney			2. Date of De. Month MAV	Day	Year 2004	3. Time of Death
į	Examir		4a. Facility Name (If not institution, gi	ve street and number)	oitai			Location of Death		4c. Co	ounty of Death	לומו
	Funeral Director		5. Social Security Number 6. 214-52-1328		(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl Month, Da May 1.	h	9 Ridho	lace (State or Foreign
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, T						1	0d. Inside City Limits
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	ath with	Funeral Director	747 Washington	7		,	,	21502			USA	try ?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, if a Medical Examinar must be notified at ADGE.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No p Rican, etc.)	1	Race - Americ Black, White, Decify: White	etc.
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Maryland 21215-0036	should be filed nd Mental Hygi marked other amatic event, II	To Be	17. Father's Name (First, Middle, Las Frank Maloney	")				18. Mother's Nam	ne (First, Middle, Vard) Ma		mame)	
	and 2 sho eelth and N n 27 is ma		19a. Informant's Name/Relationship Margy Maloney	(Type, Print) wife	1	9b. Mailin 747	g Address (Street Washingt	and Number or Ruiton Street	ral Route Numbe	or, City or To Derlan	own, State, Zip d MD	^{Code)} 21502
Baltimore,	Pages 1 and ment of He ant: If item ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Xeremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State	20b. Place ceme Scarp	of Dispose etery, crem elli Fu	sition (Name of natory or other place neral Home	e, PA	Date 5/17/2006		tion - City or To saptown	wn, State
Balt	permit. Pag Depertment Important: It eny injury o	X	21. Signature of Funeral Service Lice	The	1	22.	Name and Address Scarpel 108 Viro	îî Funeral H ginia Avenu	ome, PA e: Cumbei	rland. N	1D 21502	
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-	sertifica ding ph se as th	/Med	IF FEMALE:	23c. If yes, outcome of	f processor							
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	The law requires thet the ste has been signed by th bage 2 should be detache		Part II. Other significant conditions	contributing to death bu	t not resultin	g in the un	derlying cause giv	en in Part I.			contribute to th	e cause of death?
Division of Vital Records,	hysician: The law r his certificete has be I director, page 2 sh	Completed							24a. Was autop perfo 1 \(\text{Yes}	rmed?	4b. Were autop prior to con death?	osy findings available apletion of cause of
<u> </u>	Physician: rthis certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2□FB/	(Qutnatient	3□ DOA Oth	26. Place of Deal	th Check only o		Othor (Spec)	3
on o	ding P		27. Manner of Death 1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day	28	b. Time of Injury	28c. Injun Worl		28d. Describe h)
Divisi	i or Attending after death. Director: After i in by the fune	Certification:	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determine	De Place of Injur	y - At home (Specify)	, farm, stre			28f. Location (S City or Tox	Street and N vn, State)	lumber or Rura	Route Number,
_	To the Hospital or within 24 hours after To the Funerel Director Completely filled in Director C	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of miner: On the basis of and manner stat	amination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) and pla	d manner as sta	ated. the cause(s)
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	00		30. Name and address of person who	completed causa of de	ath (Item 23	a) (Tyne s	DOO	56355		mny	13,20	ap 2 2.
Ó	30		Mark Nelso	n M.D	. 91	3	Seton D	rive,	Pumbe,	eland	1 Mary	1/4nd 21502
	Sta Registi		31. Date filed (Month, Day, Year) MAY 1 9 2006	32. Registrar	s Signature	see s					/	

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		for State Registrar	State	of Mary	land / Dep <i>Ce</i>		ent of H			/lental		ene	16	150	82	
- 3 · 3	- Mg	1. Decedent's Name (First, Midd	le, Last)							2. Date of		David	· · · · · ·	3. Time o	Death	
Physic		Kathleen Fr	ances	Mang	litz					Month	_	2006	Year	3:20	рМ	
/Med Exami		4a. Facility Name (If not institution	n, give street and n	umber)		4b. Ci	ty, Town, o	r Location	of Death			4c. County	of Death			
	Side -	1A Northway R	oad			Gr	eenbe	1t				Princ	e Ge	orge's	;	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday	If Und	der 1 Year Is Days	If Under	r 24 Hrs. Min.	8. Date of	of Birth h, Day, Y	(ear)	9. Birth	place (State	or Foreign	
Director		577-22-1087	1 □ M 2 1 □ F	8:	3 Yrs.		Juyo	1100.0	1	Aug.	17,	1922		hingto	n, DC	
g >		Usual Residence of Decedent 10a. State 10b. Count	,	10/	c. City, Town or L	ocation								Od. Inside C	inclimite	
anyla shov	7		ce George		Green										2 □ No	
Ne M	Director	10e. Street and Number	ce deorge	. 5	Green		Zip Code				100	. Citizen of V	What Cau			
with t						101.					109			itiy :		
eath ma 23	Funeral	1A Northway R		cedent Ever	in U.S. 13	Was Do	20770		rinin? (Sn	acity Yas	or No-		USA e - Ameri	can Indian,		
ter de	Ë	1 Never Married 2 Ma	Armed	Forces?	10.0.	If Yes, s	cedent of H pecify Cuba	an, Mexica	an, Puerto	Rican, etc	2.)		k, White,			
J36	by	3 ⅓Widowed 4 □ Divorce	If Yas (Give		1 Tes	X□ No	Specify	<i>/</i> :			Specify	Whit	е		
21215-0036 d within 72 hours after death with the Maryland glene. or than "natural", or fleme 28a or 28a-f show in the Mardical Examenar must be excitited at	ed		nt's Education		16a. Dece	dent's U	sual Occup	ation	. , .		16b. Kind of Business/Industry					
Pin 7	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life.	DO NOT	work done use retired	du <i>ri</i> ng mo: d)	st of work	ang						
21.	ПO	12		(, , , , ,	Но	mema	ker					Own	Home			
other vent.	Be	17. Father's Name (First, Middle	Last)					18. Moth	ner's Nam	ө (First, М	, Middle, Maiden Sumame)					
uld b Ments	10	James W. Pett	ey					Elia	zabet	h M.	Kel:	ly				
Maryland to 2 should be file th and Mental Hy 27 1s marked oth traumatic event	2.7	19a. Informant's Name/Relation			19b. Mail	ing Addre	ess (Street	and Numb	er or Rur	al Route N	lum <i>ber</i> , C	City or Town,	State, Zip	Code)		
and and		Maureen L. Rap	hael/ Dau					Lane			a, Mi	D 2081	4			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marileal Examinating in critical at once.		20a. Method of Disposition 1 N Burial 2 ☐ Cremation	3 Removal from		 Place of Disp cemetery, cre 	osition (fi	vame of or other plac	ce)		Date	20	c. Location -	City or To	own, State		
Pag Pag ment: 1		4 Donation 5 Other (Gate of He	aven	Cemete:	ry	May _ 200	06	S	ilver	Sprin	ng, Mar	yland	
Balt permit. Departi Imports any Inji		21. Signature of Funeral Service	Licensee	0	F	2. Name ranc	and Addre	ss of Facil	lins	Funer	ral 1	Home I	nc.		0:	
o 88888		dans	900	de	5	00 U	niver	sity	Blvc	, W,	Sil	ver Sp	ring	, MD 2	0901	
bhysician and physician and physician and physician and the burial-transit	Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Meta Due t b Due t	estatic o (or as a co	C Colon nsequence of): nsequence of): nsequence of):	Canc	er							Onset and	Death	
, P.O. Box 687 that the death certificate ed by the attending phys detached for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condit	1 Live 4 Pre 9 Unk		Fetal death 31 of death 51	Other	pregnancy (specify)		1	220	Did taha	23d. Dat		Day	Year	
ds, signe	by	Congestive Hea	-		it resulting in the	andenyan	g cause giv	on in rail	1.			2 % No				
ecords, iaw requires as been sign	eted	congestive nee	ic rairar							1/1						
The The page	Completed										Was an autopsy performe (es 25)	d?	Vere auto prior to co leath? Yes	psy findings mpletion of a 2 No	available ause of	
f Vital F nysician: Th nis certificate I director, pag	Be	25. Was case referred to medic examiner?	Hoenital:				Oth	05		h (Check o						
- × · · ·	10	1 Yes 2 No	1 11		2 ER/Outpatie			4014	lursing Ho			e 6 □Oth		y)		
ling f	lon	27. Manner of Death 1 Natural 5 □ Pend	ing (Mo	te of Injury onth, Day Ye			28c. Injun Wor		TNO	28d. Desc	now edu	injury occurr	e a			
Division of tor Attending Physater death. Director: After this in by the funeral d	Certification:	3 Suicide 6 Could	mined 200. Fla	ce of Injury - Iding, etc. (S	At home, farm, st pecify)	reet, fac		Yes 2	1140	28f. Locat City o	ion (Street or Town, S	et and Numbe State)	er or Rura	al Route Num	ıb e r,	
Division of To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Ce		ing Physician: To the		mination and/or in										3)	
To the within 2 To the	Mec	29b. Signature and title of certifi					29c. Licens	e number			29d	. Date signed	(Month,	Day, Year)		
8 48 4		1	() Li	_(/_	0	100	D28									
3		30. Name and address of person	Je. 17772	مامار د	July 332) Tuno	Priett					l l	May 5	, 20	006		
)		30. Name and address of person Francine Higg			11700		svill	e Dri	ive.	Bel+	svill	le. MD	2070	7		
	ate	31. Date filed (Month, Day, Yea		Registrar's					_ , _ ,		- V al. al. a	20, 110	2070	- 1		
Regis		MAY 0 5		Pause	N. An	sele.										

06-03154 Chad Nielsen

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cer	tificate of	Death			1. No. 2	105 1538
Physicia edical Exami		Decedent's Name (First, Middle,Last)					2. Date of Death Month	Day Year	3. Time of Death 0642 hrs
euicai Examii	lei	Chad Fred 4a. Facility Name (if not institution, give st		Nielser 4t). City, Town, or Li	ocation of Death	May 10, 20	4c. County of	
		4085 Tippett Knolls Place			Indian Head			Charles	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24Hrs	_		Birthplace (State or Foreign
Director		040-78-8087 1XM	2_F 22	Yrs.	Months Days	Hours Min	Aug. 4	, 1983	Country) CT
è		Usual Residence of Decedent 10a. State 10b. County	I10c City	Town or Locatio	n				10d Inside City Limits
1 now any		MD Calvert	, sale only,		Owing	ıs			1 Yes 2 X No
uryland Sa-f sh	휭	10e. Street and Number			10f. Zip Code	,	100	g. Citizen of Wha	t Country?
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	2009 Boyds Trail			20736			USA	
with ms 23	uneral	11. Marital Status 1.	2. Was Decedent Ever in U. Armed Forces?		Decedent of Hispa s, specify Cuban, I			14. Race - White,	American Indian, Black,
r death	Fu	1 X Never Married 2 Married	Yes 2 X No				Trioditi oto.		white
rs afte ural", miner	à	3 Widowed 4 Divorced If 15. Decedent's Education (Specify only I	Dates:		Yes 2 X No S Usual Occupation		work done	Specify: 16b. Kind of Busi	
72 hours a n "natura al Examin	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life. [DO NOT use ret	red)		
5-0036 iled within 72 Hygiene I other than '	Comple	12		graph	ic desig			bluer	orint
15-C filed v I Hygi ed oth t, the		17. Father's Name (First, Middle, Last)	371 J		18		(First, Middle, Ma	aiden Surname)	DeRosier
21215-0036 ould be filed within 72 d Mental Hygiene s marked other than "tic event, the Medical.	To Be	Kurt Frederic 19a. Informant's Name/Relationship (Type	Nielsen	19b. Mailing	Address (Street	Melan and Number or I	.⊥e Rural Route Numb	er, City or Town,	
☐ 42 g 1 m		Kurt F. Nielsen,	father				e, Chesa	peake Be	each, MD 20732
re, M s l and 2 f Health if item 2 er traun		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposit crematory or other	on (Name of cemer place) Merc	etery,	Date		City or Town, State
altimore, mit Pages I ar partment of He portant: If ite jury or other tr		4 Donation 5 Other Specify:	_ Met	tropolit	an Crema	atory 5-	-14-06		dria, VA
Baltimo permit Page Department Important: injury or ot		21. Signature of Funeral Service Licensec			me and Address o	•	D 7	Ordnor	MD 20726
Physician	-	23a. Part I. Enter the disease, or complica	tions that caused the death						t Approximate Interval
/Medical		failure. List only one cause on each Immediate Cause (Final disease a. H	line. Anvino						Between Onset and Death
Examiner			e to (or as a consequence of	f):					
	-6	Sequentially list conditions, if any, leading to immediate Du	e to (or as a consequence of	f):					
	Examiner	cause. Enter Underlying Cause c.							
cuted ind transit	Exa	events resulting in death) Last Du	e to (or as a consequence of	(f):					
760, cate be execut physician and he burial - tra	lical	X UNPENDED	MENDED item#23a	a,27,28a-f	,perÆ,g85	5,5/24/06	TT		
760, ficate be es g physician the burial	/Medical		23c. If yes, outcome of pregi					23d. Date of d	
OX 687 eath certifi	sician	past 12 months.	1 Live birth 4 Pregnant at time of de	- 41-	er (Specify)	Ectopic pregn	ancy	Month	Day Year
Box 68 death certif the attending ed for use as	Physi	4 Van 3 No 0 Hekneum	9 Unknown	O Our	er (opeary)				
.O. Bo hat the de ed by the letached f	by PI	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	iderlying cause giv	ven in Part I.			ute to the cause of death?
S, P.C puires that on signed lid be deta							24a. Was ar		Probably 4 Unknown ere autopsy findings available
cord law rec has bee 2 shou	Completed						autops:	y pri	or to completion of cause of ath?
ital Recionant The Secrificate rector, page	Cou				00 Bisses	- f D th / Ob th	1 ✓ Yes 2		Yes 2 No
'ital sician: is certi irector	Be	25. Was case referred to medical examiner?	pital: 1 Inpatient 2	ER/Outpatient		of Death (Check		tesidence 6	Other Scene
n of V ling Phy After thi funeral d	<u>۔</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of In		at Work?		w injury occurred	
ion tendin eath. or: A the fur	atior	1 Natural 5 Pending 2 Accident Investigation		Fnd 6:30	AM 1□ Y€	es 2 X No	subject h	anged self	£
Division of Vital Records, tat or Attending Physician: The law requir as fair cleath. In Director: After this certificate has been seled in by the funeral director, page 2 should!	Certification:	3 X Suicide 6 Could not be	28e. Place of Injury - At he	ome, farm, street	, factory, office bu	ilding, etc.	28f. Location (St	reet and Number ate) 4085 Tij	or Rural Route Number, City Popett Knolls PI
Di ospital hours a nneral I		4 Homicide determined 29a. Certifier 1 Continue Physician	(Specify) Shed						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: 0	: To the best of my knowled n the basis of examination a	lge, death occurr and/or investigati	ed at the time, date on, in my opinion,	e and place, and death occurred	d due to the cause at the time, date a	(s) and manner a nd place, and du	s started, e to the cause(s)
To the within To the comple	Mec	29b. S/gna/ure and title of certifier	nd manner stated.		29c. License				(Month, Day, Year)
		Caral LA	elan		O.C.M	И.E.		May 11, 200	6
		30. Name and address of person who cor			tat D !!!	- MD 0465	1		
			Medical Examiner		treet, Baltimo	ore, MD 2120)1 		
S Regis	tate trar	W# N \ 4 (° 00	32. Redistrar's Signatu	S. Sp	we				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. # 18 CMH State of Maryland / Department of Health and Mental Hygiene State
Registrar AACO HEALTH DEPT. 5/10/Sertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician April 30, 2006 1:10 РМ Daniel Patrick O'Connor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Bowie 16208 Pointer Ridge Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/02/1956 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**XX**M 2□ F DC561-02-5754 49 Washington, Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show id 2 should be filed within 72 hours after death with the Maryla th and Mantal Hygene. 27 Is marked other then "natural", or frems 23a or 28a-f shov traumatic event, in a Madical Examinar must be multilled at 1 XYes 2 No Directo Maryland Bowie Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20716 16208 Pointer Ridge Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: ģ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Kascon Construction Superintendent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny hijury or other traumatic event 2008. Be Barbara Linestrom John Thomas O'Connor Lindstrom 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1215 Port Echol Lane Bowie, MD 20716 John Thomas O'Connor/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens 05/04/2006 Davidsonville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf **Physician** disease or condition resulting in death) Hyocardia now /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of) Examiner noing physicien and use as the burial-transit The law requires that the deat certificate be executed resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to of Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown signed by I Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 Unknown 1 ☐ Yes 2 ☐ No should I 19 12 CUSTONA VA 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Hypolopolonie page 2 s 2 No certificete 1 Yes Attending Physician: After this certification Be Was case referred to medical 26. Place of Death (Check only one) examiner? ✓ Yes 2 No Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 fnpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 9 29a. Certifier 🖸 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifier 29c. License number 047603 2106 ho completed cause of death (flem 23a) (Type, Print) 4000 Metchellylle Rd Ball Bowci, MO 2016 30. Name and add Boyce, MP 31. Date filed (Mor Registrar's Signature State Registrar

			1 - Sta Reg	r ata gistrar		State of Ma	arylan	-		ent of F ate of		Mental I	lygier Rag. 1	700	6	15885
	Physici /Medic		1. Dece	edent's Name	(First, Middle, Las	harles Mo	rton	PASCAL				2. Date of May 3)6 Y	ear .	3. Time of Death 3:30 A M
}	Examin		4a. Faci	ility Name (If	not institution, give	street and number)			4b. C	ity, Town, o	Location of Deal	h	4	4c. County of	Death	
	Funeral Director		5. Socia 577 –	1 Security Nu -03-778	mber 6. Se 1	1vd., #73 PX 7. Ag		last birthday) Yrs.	If Ur Mont		Chase If Under 24 Hrs Hours Min.	8. Date of (Month,	Birth Day, Yea	Monto 1913 Wa	Birthola	ry ace (State or Foreign ngton, DC
	and w		Usual R 10a. Sta	Residence of Date	10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
	Manyi fish	tor	Marv	land	Montgom	erv	C	Chevy (has	e						1 ☐ Yes 2√☐ No
	h the	lrec	-	reet and Num					_	Zip Code			10g. (Citizen of Wha	t Count	ry?
	23a c	alD	555	5 Frie	endship B	1vd., #73	5			2081	5		Uni	ited St	ate	S
21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Healih and Mental Hygiene. It item 27 is marked other than "natural", or items 23s or 28s-f show or or other treumatic event, it is Misclical Examinate market neitlind at	Completed by Funeral Directo	1 🗆	rital Status Never Marrie Widowed 4	d 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give X Year or Dates:				cedent of H pecify Cuba 2 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or to Rican, etc.)	No-		America White, e Whi	tc.
15-	"natu	lete		(Specif	15. Decedent's Ed y only highest gra	lucation de completed)		16a. Dece (Give	lent's U kind of	sual Occup work done	ation during most of wo f)	rking	16b.	Kind of Busin	ess/Indi	ustry
12	within ene. than "	дшс	Elem	entary/Secon	dary (0-12)	College (1-4or 5	i+)	Busin			"		Li	iauor/R	ea1	Estate
ld 2	il Hyg other	Be C	17. Fath	her's Name (F	First, Middle, Last)						18. Mother's Na		dle, Maid			
/lar	Menta Menta arked	To E	Н	larry P	ascal						Mario	n Shin	as			
Maryland	12 should be filed within hand Mental Hygiene. 7 is marked other than "treumatic event, it a Men				me/Relationship (7				_		and Number or R		-		te, Zip (Code)
	1 and Health em 27 ther t			a Levi	ne, Daug	hter	20b. P	lace of Disno	sition /	Vame of	er Drive	Date		MD 20 Location - Cit	1854	un State
Baltimore,	permit. Pages 1 and 2 Department of Health a importent: If Item 27 is any injury or other tree		1 X	Burial 2		Removal from State	Kes	her Is	rae	1 Cem	etery05/0	05/06				hts, MD
Ball	permit. Pa Departmen importent: any injury.		21. Sig	nature of Fun	graf Service Licen	sa)e		18	PET	THERY	^s ffeb⊮ew 1 St N	Funera			21	0012
	100		23a. Pa	art1. Enter the	e disease, or comp	olications that caused one cause on each li	the death								i	Approximate Interval Between
E	Physician		disease	liate Cause (F e or condition	inal	aCardiom	vonai	thv								Onset and Death
1	/Medical Examiner		resultin	ng in death)		Due to (or as										
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	uted d ansit	E	cause. Cause	Enter Underl (Disease or in tiated events	lying njury	,	,									
oʻ	an an an rial-tr	Exa	resultin	ng in death) La	ast	Due to (or as	a consequ	uence of):								
68760,	ificate be executed g physician and as the burial-transit	edical Examiner				d									_	
	TO 65		IF FEM	AALE:		020 16 100 0 100	-4									
Box	attending for use	slan/	in	the past 12 n	nonths?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal	death 3		pregnancy (specify)				23d. Date of Month		y Day Year
o.	that the death cer ed by the attendir detached for use	by Physician/M		☐ Yes 2☐ ☐ Unknown	No	9□ Unknown	tille of de	3 L	Ouriei	(specify)			-			
۳,	res that signed b	y P	Part II.	Other signific	cant conditions o	ontributing to death b	ut not resu	ılting in the u	derlyin	g cause givi	en in Part I.	23e. D	id tobacco	use contribu	e to the	cause of death?
ords	w require been sig should b	ted k										1	Yes	2 □ No 3 □] Probal	biy 4XUnknown
of Vital Records,	has has	Completed										24a. W	as an topsy orformed?	prior	to comp	sy findings available pletion of cause of
a		e Co	25 Was	s case referre	ed to medical						OC Blace of Day	1 ☐ Ye	s 2 1		Yes 2	!□ No
Š		To B	exa	miner? Yes 2X1	<u> </u>	Hospital: 1 Inpatie	nt 2 🗆 l	ER/Outpatien	3	DOA Othe	26. Place of Dea er: 4 ☐ Nursing H			6 ∏Other (Specify)	-
101	ding Phys T. After this funeral di	n: T	27. Mar	nner of Death	,	28a. Date of Inju (Month, Da	ry	28b. Time of		28c. Injury Work				ury occurred	specify,	
SIO	endin eath. or: Af	catlo	2 🗆	Accident	5 Pending investigation			,,	М		Yes 2□No					
Division	after danset di Direct	Certification:] Suicide] Homicide	6 ☐ Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	et, fac	ory, office			n (Street a Town, Sta		r Aural I	Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C		ertifier Check only 2	Certifying Ph □ Medical Exam	ysician: To the best liner: On the basis of and manner sta	examinat	wledge, death ion and/or inv	occum	ed at the tim on, in my op	ne, date and place pinion, death occu	e, and due to to irred at the tirr	he cause(ie, date ai	s) and manne nd place, and	r as stat	ted. he cause(s)
	To the To the Complet	Σ	29b. Sig	gnature and ti	itle of certifier	10				29c. License	number		29d. D	ate signed (M	onth, Da	ay, Year)
	20			44	one	J. Du	Ina	m		D 001	4111 MD		Ma	y 3, 20	006	
						ompleted cause of d M.D., 553				enue,	Suite 8	300, Ch	.evy	Chase,	MD	20815
	Sta Registr		31. Date	te filed (Month		32 Registra	ar's Signat	ure for		į						

give street and number) A MANN CINT 6. Sex 1	yrs. ty, Town or Local Parsons	If Under 1 Year Months Days	Location of Dea CUS ON If Under 24 Hrs Hours Min	8. Date of Birth	30 CV 4c. County of De	nath irithplace (State or Foreign Country)
give street and number) A MANN CINT 6. Sex 1	Vast birthday) Yrs. Ty, Town or Local Parsons	If Under 1 Year Months Days ation	If Under 24 Hrs	104	4c. County of De	nath irithplace (State or Foreign Country)
Toc. City 1 Was Decedent Ever in U. Armed Forces? 1 Yes, Give 1989.	yrs. ty, Town or Local Parsons	If Under 1 Year Months Days ation	If Under 24 Hrs		4c. County of De	irthplace (State or Foreign Country)
6. Sex 7. Age (In yrs.) 1	Yrs. ty, Town or Loca Parsons	Months Days ation sburg	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day 11/22/	9. E 1917 M	Country)
Dad 10c. City 10c. City 10c. City 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes. 2 No If Yes. Give	Parsons	burg				aryland
Dad 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 No If Yes, Give	Parsons	burg				•
Dad 12. Was Decedent Ever in U. Armed Forces? 1 Yes 2						10d. Inside City Limits 14☐ Yes 2 ☐ No
12. Was Decedent Ever in U. Armed Forces? 1		1		1.	10g. Citizen of What	Country?
12. Was Decedent Ever in U. Armed Forces? 1		21849			USA	
ed 1 ☐ Yes 2 ☑ No If Yes, Give	i.S. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Specify Yes or No-		nerican Indian,
Year or Dates:		Yes 2X No	Specify:	ito Alcan, etc.)	Black, W Specify:	white
s Education grade completed)	(Give k	ent's Usual Occupa	uring most of wo	orking	16b. Kind of Busines	ss/Industry
College (1-4or 5+)	Homen	O NOT use retired))		Domestic	
ast)	пошен	laket	18. Mother's Na	me (First, Middle,		
oore Sr.				a Timmons		
ip (Type, Print)				onsburg,	r, City or Town, State MD 21849	, Zip Code)
20b. P	Place of Disposi	ition (Name of atory or other place	9)	Date	20c. Location - City	or Town, State
		Memoria.		6/06	Salisbu	
icensee	221	Name and Address 10110Way 1001 Snow	Funeral Hill Rd	Home Pro	ofessional oury, MD 2	Association 1804
complications that caused the death				c or respiratory ari	rest,	Approximate Interval Between Onset and Death DAYS
Due to (or as a conseq	quence of):					DAYS
b. ASPIRATI Due to (or as a conseq	quence of):					WEEKS
C. METABL		ACIO	03/3			
		URE				YEARS
1 Live birth 2 ☐ Feta	al death 3 🗆				23d. Date of o Month	delivery Day Year
	-					to the cause of death?
MUCHINE : UIE	·······································		361132	24a. Was a		
				perfor	med? death	autopsy findings available o completion of cause of ? es 2 \(\text{\text{NO}}\)
			26. Place of De	ath Check on or	ne)	
		3L DOX	4 🗆 Nursing			oecify)
	28b. Time of Injury			28d. Describe h	ow injury occurred	
and 288. Place of Injury - Auto	nome, farm, stre ify)	et, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
Examiner: On the basis of examina	owledge, death ation and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occ	e, and due to the durred at the time, d	cause(s) and manner date and place, and c	as stated. iue to the cause(s)
					29d. Date signed (Mo	onth, Day, Year)
6 11 11		00	06291	-	MAY	, 2006
man me en year and a first			n. V. Cim	1 60.00	2 SAZISBU	ay Mn 2180
111-MARI MI		- 001	010/3/01	1 201116 1	7171	
Sini	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown Hospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At houlding, etc. (Special of Month) 28b. Place of Injury - At houlding, etc. (Special of Month) 28c. Place of Injury - At houlding, etc. (Special of Mont	23c. If yes, outcome of pregnancy 1	23c. If yes, outcome of pregnancy 1	23c. If yes, outcome of pregnancy 1	23c. If yes, outcome of pregnancy 1	23d. Date of of Date of Check only one of Death (Specify) 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of of Month 23d. Date of Other (Specify) 23d. Date of Other (Specify) 23d. Date of Other (Specify) 23d. Date of Other (Specify) 24d. Was an autopsy performed?

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H <i>te of L</i>	ealth a Death	and N	lental Hyg	giené U Reg. No.	Ub	10001
	. n		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	nth Day	V	3. Time of Death
	Physici /Medio		Victoria Ruby Je	wel Proul	x						May 1,		Year	12:00 A ^M
1	Examir		4a. Facility Name (If not institution,	give street and nu	umber)		4b. City	, Town, or	Location o	of Death		4c. Coun	ty of Death	
		, ya	714 Valley Road					noxvi					ederi	
	Funeral		5. Social Security Number 402–30–4168	3. Sex 1 ☐ M 21231_F		s. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birti (Month, Da)	/, Year)		lace (State or Foreign itry)
	Director		Usual Residence of Decedent		77			<u>L</u> l			March 17	, 1929	Kent	ucky
	yland		10a. State 10b. County		10c. C	City, Town or Lo	cation						1	0d. Inside City Limits
	Mar si	to	Maryland Washing	gton		Knoxvi	.11e							1 ☐ Yes 2√ No
	or 28	ire	10e. Street and Number				10f. Z	p Code				10g. Citizen of	What Cour	itry?
	eth w	rai	714 Valley Road					21	758				d Stat	
	er de	nue	11. Marital Status	Armed F		U.S. 13. 1	Was Deci f Yes, sp	edent of His	spanic Orig	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - Amendack, White,	
36	filed within 72 hours after deeth with the Maryland Hygiene. yther than "natural", or itams 23a or 28a-f show ent, the Mackeal Examilier must be confilled at	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	d 1 ∐ Yes If Yes, G Year or t			I □ Yes	2 % No	Specify:			Spec	⊮.Whit	e
21215-0036	2 hou	led	15. Decedent's	Education		16a. Deced	lent's Usi	ial Occupa	tion			16b. Kind of	Business/Ind	lustry
215	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)		(1-4or 5+)	(Give	kind of w DO NOT	ork done d use retired)	u <i>ring</i> most	t of work	ing			,
7	giene giene	NO.		2		Antiqu	ie De	ealer				Ant	iquiti	les
pu	d oth	Be (17. Father's Name (First, Middle, La						18. Mothe	ır's Nam	e (First, Middle,	Maiden Suma	me)	
Maryland	Men	ဥ	Kenneth Jesse De								arl War			
Nar	12 sh h and 7 ls m		19a. Informant's Name/Relationshi			19b. Mailin	g Addres	s (Street a	nd Numbe	r or Rur	al Route Numbe	r, City or Town	n, State, Zip	Code)
e)	1 and Health em 2 ther 1		Lisa Proulx / Da 20a. Method of Disposition	ughter	20b	714 V	In 116	y Rd.	. Kn	OXVI	lle, MD		City or To	
Jor	nt of nt of nt of nt of		1 Burial 2 Tremation 3		Clare	Place of Dispo cemetery, cren						20c. Location	•	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Mucical Examples must be restitled at anose.		4 ☐ Donation 5 ☐ Other (Spe	7	Re	sthaven					, 2006	Frede	rick,	Maryland
Ba	Depar Impo	١.,	7///			Re	sth	iven l	uner	al S	ervices	, Skko	t Cody	P.A.
	A AND THE RESERVE OF THE PERSON OF THE PERSO		23a. Part1. Erker the disease, are shock, or heart failure. Use or	omplications that	caused the dea	ath. Do not ente	or the mo	de of dying	, such as	cardiac o	Hwy. Fr	ederic. est,	k, MD	Approximate
1	Physician		Immediate Cause (Final disease or condition											Interval Between Onset and Death
1	/Medical		resulting in death)		(or as a conse	oma of to due not of).	ne r	erre r	Juct				3	.5 months
	Examiner		Sequentially list conditions,	b. ———										
	p ti	Examiner	d any, leading to immediate cause. Enter Underlying	Due to	(cr as a conse	quanca of):								
	and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conse	cuence of):	_							
8760,	icate be executed physicien and the burial-transit	alE			(0) 43 4 00//30	quonos or).								
687	+	edical		d										
Вох	death certific e ettending p od for use as	N/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregr							23d. D	ate of delive	TV.
m	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregi	birth 2 Fet nant at time of		Ectopic p Other (s	regnancy pecify)						Day Year
P.O.	s thet the death certi ned by the ettending s detached for use a	Physician/M	9 🗆 Unknown	9□ Unkn										
Ś	0 00	by F	Part II. Other significant condition	s contributing to d	leath but not re	sulting in the ur	derlying	cause giver	n in Part I.		23e. Did tol	pacco use con	ntribute to the	e cause of death?
ord	w requir been si should I	ted					_				1 🗆 Ye	as 2□No	3 Proba	ably 4 Unknown
Record	e taw has b	Completed									24a. Was a autops	y	prior to con	sy findings available
	Th Dag										perform 1 Yes	ned? 2 ∏ No	death?	2 No
<u> </u>	Physician: this certificatal director, p) Be	25. Was case relerred to medical examiner?	Hospital:				Other	-		(Check only on			
ō	ding Phys h. After this funeral dir): To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of		JA	4 🔲 (90)		ne 5 Reside 28d. Describe ho)
o	Attending r death.	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga		ith, Day Year)	Injury	м	28c. Injury Work? 1 🗌 Y	es 2 1			mijory social		
Division of Vital	or Attenation after deat	Hice	3 Suicide 6 Could no 4 Homicide determin	ad 288. Place	of Injury - At h	nome, larm, stre	et, lactor	y, office			281. Location (St	reet and Num	ber or Rural	Route Number,
ā	s after al Dire ed in b	Certification:	4 Notticide	build	ing, etc. (Speci	ny)					City or Towr	i, State)		
	To the Hospitel or within 24 hours afte To the Funeral Dirr completely filled in I	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the	e best of my kn	owledge, death	occurred	at the time	, date and	d place, a	and due to the ca	ause(s) and m	anner as sta	ited.
	To the Ho within 24 To the Fu	Medi	0.107	and man	ner stated.	41011411401111								
	wit To	-	29b. Signature and Itle of certifier	1 1			29	c. License	number		2	9d. Date signe	ad (Month, E	Pay, Year)
	17-		1 / 1/00	وس ب				D 437	80		Ma	y 1, 2	006	
	V		30. Name and address of person we Kevin Hohl, M.D.					S	huro	h s. E	raple14.	Malla	o to accommod	MD 01760
	Sta	te	31. Date liled (Month, Pay, Year)	2008 32.	egistrar's Sign	ature	,,,,	5.	JITUL C	II W E	Lanklin	, ritaal	erown	, FID 21/69
- 3	Registr	ar	mi. 1 0 9	2000	your.	N A	BALL	,						

DHMH 17 Rev 1/2001

06-03169 Ruth Master

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	ate or maryn	•	tificate of		ia wientai i		eg. No.	1 1 1 1 0 0
Physicia	ın/	1. Decedent's Name (First, Midd						Date of Dea Month	Day Year	3-Time of Death
wedicai Examii	ıer	Ruth Master Per		ımher)	- 1,	4b City Town (or Location of Dea	May 10, 2	4c. County of Deal	1425 hrs
		10919 Deborah Drive	in, give ellect and the	aniber)		Potomac	or Ecodition of Doc	401	Montgomery	"
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye	ar If Under 24H	lrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi	
Director		None	1 M 2 X F	45	Yrs	Months Da	ys Hours M	o3/26/	1961 Fore	_{ountry} Colombia
	ļ	Usual Residence of Decedent								
W an	ł	10a. State 10b. County Maryland Montgo	mery	Potor	Town or Locati nac	ion				10d Inside City Limits 1 Yes 2 XXNo
yland a-f sho	ğ	10e. Street and Number				10f. Zip Code		11	0g. Citizen of What Cou	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28af show any or other traumatic event, the Medical Examiner must be notified at once.	Director	10919 Deborah D	rive			20854		Ī	Colombia	and y
with the ms 23a be noti		11. Marital Status		cedent Ever in U.				Specify Yes or No		rican Indian, Black,
or item	uneral	1 Never Married 2 XM	arried Armed F	orces?	If Y	es, specify Cuba	an, Mexican, Puer	to Rican, etc.)	White, etc.	1+4
after	by F		orced If Yes, Give Yes or Dates:		1 _X	Yes 2 N	o specify: Co	lombian	Specify:	
hours 'natu		15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest gra				ation (Give kind o e. DO NOT use re		16b. Kind of Business	/Industry
36 hin 72 e. fthan '	ple	Elementary/Secondary (0-12)	College (II om om	-1				
5-0036 iled within 7 Hygiene. I other than the Medica	Completed	17. Father's Name (First, Middle			Homem	aker	18.Mother's Nar	me (First, Middle, I	<u>LOwn Home</u> Maiden Surname)	
21215-0036 hould be filed within 72 hours afte and Mental Hygiene is marked other than "natural", title event, the Medical Examiner	Be	Isaac Master					Blanca	Pena_		
ID 21215-00; should be filed withing and Mental Hygiene 7 is marked other thatic event, the Mediatic event	-1	19a. Informant's Name/Relations							nber, City or Town, State	e, Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		Juan F. Sanchez 20a. Method of Disposition	-Spouse	20b. F	10919	Deboral	Drive,	Potomac Date	MD 20854 20c. Location - City of	Town State
Baltimore, Normannia, Pages 1 and Department of Healt Important: If item injury or other tran		1 Burial 2 XXCremation	n 3 Removal f	rom State	crematory or oth	ner place)	matory5-			
Baltimo permit. Page Department c Important:	-	4 Donation 5 Other S 21 Signature of Funeral Service		1101					Brentwood,	
Baltil Permit Departm Importa		Chi from 1	waln the	41/	D-11	zo Pool	sville.	mple Tri	bute, 1040	Rockville
Physician		23a. Part I. Ent. r the disease, or failure. List only one cause	complications that o	cause the death.	Do not enter the	ne mode of dying	g, such as cardiac	or respiratory arm	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	ŀ	Immediate Cause (Final disease	a Pseudoep	hedrine) a	and alcoh	ol intoxi	cation	dimie, Ace	camiopien, d	Death
		or condition resulting in death)		a consequence of	F):					
	ē	Sequentially list conditions, if any, leading to immediate		a consequence of	f):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C	a consequence of	F).					
uted Id ransit		events resulting in death) Last	d.	a consequence of	17-					
Box 68760, death certificate be executed he attending physician and of for use as the burial - transit	/Medical	X UNPENDED	X AMENDED	item#1,23	Ba,27,28a	-f,perME,	g855 , 5/30/	'06 TT		
760, ficate be g physic the bur	/Me	IF FEMALE:		outcome of pregr	nancy				23d. Date of deliver	у
68 certifi	ian	23b. Was decedent pregnant in the past 12 months?	Live	birth nant at time of dea	ath =		Ectopic preg	nancy	Month	Day Year
Box e death c the atten ed for us	Physician	1 Yes 2 V No 9 Un	known 9 Unkn		5 ∐ Oti	her (Specify)				
· 4 > 5		Part II. Other significant condi	tions contributing t	o death but not re	esulting in the u	inderlying cause	given in Part I.		obacco use contribute to	
Division of Vital Records, P.O ral or Attending Physician: The law requires that its after death "I Director: After this certificate has been signed be led in by the funeral director, page 2 should be detax	ed by			.				-	s 2 No 3 Pro	
Records, The law requirecate has been a	Completed							24a. Was autop	sy prior to	utopsy findings available completion of cause of
Rec The la cate h	ĕ							perfor 1 ✓ Yes	rmed? death? 2 No 1 Y	es 2 No
tal F cian: certifi ector,	Be	25. Was case referred to medica examiner?	Hospital:				ce of Death (Chec			
f Vi Physi er this	ဥ	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of Ir		Other Nurs		Residence 6 Othe	r: Scene
nding nding th :: Aft	ion:	1 Natural 5 Pen	(Mont)	h, Day,Year)			Yes 2XX No			
iSiC r Atter er dea er dea irector	ficat	2 Accident Inve	stigation 110 3/	10/2006 be of Injury - At ho	unk ome, farm, stree			28f. Location (S	ngested drugs Street app Nymber of Ri	and alcohol ural Route Number, City ran Dr.
Div nital or urs aft rral Di	Certification:		Id not be (Specify)	Home				Potomac,	MD 10919 Debo:	ran Dr.
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death To the Funeral Director: After this certificate completely filled in by the funeral director, page		(Ondon only	-						e(s) and manner as star	
To the within To the comple	Medical	X	and manner :		nd/or investigat			d at the time, date	and place, and due to th	e cause(s)
	Σ	29b. Signature and title of certific		$\overline{}$			ise number		29d. Date signed (Mo	nth, Day, Year)
		(laut	new	2		0.0	.M.E.		May 11, 2006	
		30. Name and address of person Laron Locke MD.	n who completed cau Assistant Medica			Street, Balt	imore, MD 21	201		
91	ate			43						· · · · · ·
Regist		31. Date filed (Month, Day, Year)	6 2006	egistrar's Signatu	J. Alga	-				

				State of Ma	ryland / I	-	nent of H			iene	96	15890
			1. Decedent's Name (First, Middle, Last)					***************************************	2. Dete of Deal		Vaar	3. Time of Death
	Physicia	_	AUN REGA	N					Month MA	Day 03 2	Year OOL	4:00 AM
	/Medica		4e Fecility Neme (If not institution, give s			_	4		Location of Deeth	4c. County		
	LXammi		BRINTON WOO	DS RUK	251116	4-RE	HAB	SYKE	SUILLE	(2)	ARK	OLL
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last bi	rthday) If U	Inder 1 Year oths Deys	If Under 24 Hr		Year)	9. Birthpi	tace (State or Foreign
	Director		179 - 16 - 3612	M 2 ⊠ F	83	Yrs.	illis Doys	Tiodis Will	Oct. 28			sylvania
	p >		Usuet Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location					11	Od. Inside City Limits
	anyle	۲	Md. Carro			Airy					,	1 ☐ Yes 2 🗖 No
	28a-1	8	10e, Street end Number				f. Zip Code			0g. Citizen of W	hat Coun	to/2
:	N N	Funerai Director		d		10	i. Zip Code	21771	'	United		•
	me 23	era	6603 Wind Ridge Ro	2. Was Decedent Ev	ver in U.S.	13 Was F	ecedent of Hi		Specify Yes or No-		- America	
_	iten d	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🗷 No		If Yes,	specify Cuba	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		c, White, e	
מכ	urs el	۵	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Y	es 2.22 No	Specify:		Specity:	Wh	ite
215-0020	filed within 72 hours eftar death with the Marylend Hygiens. Wher then "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	- 15. Decedent's Educ	ation	16a	. Decedent's	Usual Occupa	ition	orkina	16b. Kind of Bu	siness/Inc	lustry
5	Thin 7	힐	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	OT use retired,	uring most of wo	Jiking .			
7	gien.	5	12	2		Nurse				Medica		
2	be filed within tal Hygiena. Id other than overt, the Ma	Be	17. Fether's Name (First, Middle, Last)						ame (First, Middle, M		э)	
<u>X</u>	should be filed and Mental Hygi rmarked other umatic event, I	2	Walter S. Hoo	ver				Alida		<u> </u>		
E	2 2 2 2		19a. Informant's Name/Relationship (Typ			_			Rural Route Number Silver Sp			Code) 20904
	t Heaith tem 27 other tr		Robert Scalley / S	5011		of Disposition		DIIVE,		20c. Location - 0		
Baltimore,	Internation of the state of the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Re	emoval from State	cemete	ry, crematory	or other place	-				
	permit. Pages Department of is Important: if Its any Injury or o	-	4 □ Donation 5 □ Other (Specify)		Metro	-	an Crem	_	5/4/06	Alexan	dria	, va.
e n	permit. Departn Imports any Inju		21. Signature of Funeral Service License	2 0		Mu			Funeral			
			Murief & R	Darke	~				Laytons		Id. 2	
	-		23a. Part1. Enter the diseese, or complic shock, or heart failure. List only on	e cause on each line	ne death. Do	not enter the	mode of dying	, such as cardia	ac or respiratory arre	est,	1	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final	10	- 0		-101	11/2 00	ena Acc	125	1	
	Examiner		diseese or condition resulting in death) a.	HR7	GK105CL	exeric	CARIS	יט כדיטטו	ICAR DIS	ONE		
		ē		D	ue to (or as a	consequence	∋ or):				1	
	icete be executed physician en s tha burial-transit	cal Examiner	Sequentially list conditions	D	ue to (or as a	consequence	e of):		*			
o ·	cete be executed ohysician en tha bunal-transi	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,	,	,					
8760	ate be nysici ha bu	ca	Cause (Disease or injury that initiated events resulting in death) Last	Di	ue to (or as a	consequence	of):				+	
9	ng pt ng pt	D .	Todaking in dodkiny cust								1	
ROX	raquiras that the death certific been signed by the attending p should be detached for use as	Physician/M	0.									
0	the a	/sic	Part II. Other significant conditions cont	ributing to death but	not resulting i	n the underly	ing cause give	n in Part I.	23b. Did to	bacco use con	tribute to	the cause of math?
<u>. </u>	requiras that the de been signed by the s should be detached		SIABETES M	EZUTUS					1 🗆 Y	s 2 No	3 🗌 Prob	ably 4 Unknown
က်	iras t signe d be d	ğ	DIABETES M CELEBADVASC	9					24a. Was a	a autonou	24h We	re autopsy findings
Š	raqu	ete	CELEBROVASC	WAR D	SCASE				perform		ave	ilable prior to npletion of cause
Records,	hysicien: Tha law his cartificate has b il diractor, page 2 s	Completed	<i>a t1</i>	ON- EN	· · · · · · ·					1		léath?
_ '	n: Fha licate h r, page	ပ္ပို	25. Was case referred to medical	ARI THI	CURE				1 □ Y€		1 L	Yes 2□ No
5	cartil cartil	o Be	examiner?	ospital:	2 ER/O	stantions OF	DOA Othe	w: /	eath (Check only on Home 5 - Reside		- /C:/	
ō	co	⊢⊦	27. Menney of Deeth	1 ☐ Inpatient	28b.	Time of	28c. Injury Work		28d. Describe ho			,
<u>.</u>	th: Afte	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury M		? ∕es 2 □ No				
DIVISION	Attending Physician: ordeath. ector: After this cartific by the funeral diractor,	<u> </u>	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, fa	arm, street, fa	ctory, office		28f. Location (St. City or Town	reet and Numbe	r or Rura	Route Number,
	s afte	Certification:	4 Homolde	building, etc.	(Specify)				Oily or rown	, Clarey		
	ospit hour uners		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin									
5	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	one)	end menner state								
	S T S	Σ	29b. Signature and title of certifier				29c. License	numper	2	9d. Date signed	(Mo⊓th, L n⊿	рау, үөаг)
	3/		· Called Jule	Jus)	9		020	106		2/5/0	6	
			30. Neme end address of person who cor	mpleted ceuse of dea	ath (Item 23e)	(Type, Print)	2n/	D-DT.	DO: THE	CAS D. D.	- 1611	7 71700
		å	31. Dete filed (Month, Day, Year)	10011	's Signature	9 10	W []	174619	ie co	CROPOR	Sul	01/87
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DHMH 16 Rev 6/95

		·	1 - State Registrar	State of Mary		artment of rtificate of			Reg. No. 2 0	05	15891
ſ	Physicia /Medic		Decedent's Name (First, Middle, Last)	Rose R	OSENFELD			2. Date of De Month May 3	Day	Year	3. Time of Death 5:45 A M
1	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of De		4c. County	of Death	
			Hebrew Home of Gre			Rockvi			Monte		
	Funeral		5. Social Security Number 6. Sex 1 □	M 2X F	yrs. last birthday) Yrs.	If Under 1 Yea Months Days		in. (Month, D.	ay, Year)	Coun	,,
	Director		185-07-9411 Usual Residence of Decedent		94			Dec. 2	5, 1911	Russ	31 a
	/land		10a. State 10b. County	100	c. City, Town or Lo	ocation				10	Od. Inside City Limits
	Mar.	ţċ	Maryland Montgome	ry	Rock	ville					1 □ Yes 2 □XNo
•	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Coun	try?
	23a	rai	1801 E. Jefferson				20852		United		
	er de	une	, t, mana states	2. Was Decedent Ever Armed Forces?		Was Decedent of If Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or Netro Rican, etc.)	0- 14. Had Blad	e - Americ ck, White, e	
36	irs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No: If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	o Specify:	,	Specify	whi	te
ğ	2 hou	ted	15. Decedent's Educ		16a. Dece	dent's Usual Occi	upation		16b. Kind of B	usiness/Ind	lustry
212	hin 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	e during most of v ed)	working			
21	er th	Completed	12		Sec	retary			Synag	_	
ng	d oth	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle		ne)	
<u>\Z</u>	s Men s Men narks	2	Nathan Cholod 19a, Informant's Name/Relationship (Type		405 14-18	- Add /Ch		a (unkno Rural Route Numb		Ctata Zia	Codel
Maryland 21215-0036	d2 st th and 7 to n traun		Allen Rosenfeld, S	•		_		ruckee,	-	-	C00#)
	1 an Heali		20a. Method of Disposition		Ob. Place of Dispe	osition (Name of		Date	20c. Location -		wn, State
<u>o</u>	ages ont of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)		сетеtегу, сге Har Zion	matory or other pi	1	05/06	Collin	oda1e	РА
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "netural", or iteme 23s or 28s-f show any followy of other traumatic event, the Madical Exemiting natural the motified at angre.		21. Signature of Funeral Service License		The second secon			Funeral		Баатс	, 111
ä	Ped in a					orchinsk 54 Carro	y Hebrew	Mu Wesh	forten	חר 2	0012
	Physician /Medical Examiner		23a. Part: Epier the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	levetic	ter the mode of dy	ying, such as card	diac of respiratory	arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
P.O. Box 68	ath certific stending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnan □ Other (specify)				te of delive	ry Day Year
Records, P	Se P8 6	δ	Part II. Other significant conditions con		ot resulting in the u	ınderlying cause ç	given in Part I.		tobacco use cont	ribute to th 3 ☐ Prob	e cause of death? ably 41 Unknown
ပ္ပ	aw requir 1s been si 2 should t	Completed						24a. Wa	s an 24b.	Were autor	osy findings available
Æ	0 5 0	E						- auto perf 1 ☐ Yes	ormed?	death?	npletion of cause of 2 No
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<u>></u>	\$ w =	ToE	examiner?		2 ER/Outpatie	nt 3□ DOA	other: 4 Nursin	g Home 5 ☐ Res	idence 6 □Oth	er (Specify	•)
o u	ing Ph		27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	W	uryat lork? □Yes 2 □No	28d. Describe	how injury occur	red	
Division of Vital	To the Hospitel or Attending within 24 hours effer death. To the Funerel Director: Affer completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S					(Street and Numb own, State)	er or Aura	l Route Number,
Ö	Itel or irs efter rel Dire					WILL SERVICE STREET					
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	To the Hospitei within 24 hours e To the Funerei I completely filled	Med				29c. Lice	nse number		29d. Date signe	d (Month, I	Day, Year)
	F 5 F ŏ		Han I wi	il ~ s		Ari	778		M 2	21.01.	
	6		30. Name and address of person who co	impleted cause of death	(Item 23a) (Type	, Print)	2.0		17/7	CUO 10	
			Gary B. Wilks, a	0 6(21	montrese	lead	Rockun	11cms	20+5	2	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 0 5	mpleted cause of death (b) (6 (2 / 32. Registrar's	Signature	book					

State of Maryland / Department of Health and Mental Hygiene For Stata Ragistrai Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:16 pM Vera Mary Swindell 4 2006 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Havre de Grace 4217 Rock Run Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec. 26, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2XF 1919 Yrs Maryland 215-16-0329 86 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a. State or 28e-f show other treumetic event, the Medical Examiner must be notified at 1 Yes 2 No Havre de Grace Directo Maryland Harford 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 21078 U.S.A. 4217 Rock Run Road Items 23e Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker Twelve Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Cora Strohmer Martin Joseph Miller ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4217 Rock Run Road, Havre de Grace, Maryland 21078 Department of Health a Importent: If item 27 is eny injury or other tret once. Mary S. Shelley (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/09/06 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenset Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mocordier disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has certificate l 2□ No 1 Yes 1 Yes Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Hospital: 4 Nursing Home 5K Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) own 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State 5 2006 Registrar

Disconi		Registrar		Ce	rtificate of	Death		Reg. No.	000	15893
Physic	cian	Decedent's Name (First, Middle, Decedent's Name (First, M					2. Date of Dea Month	ath Day	Year	3. Time of Death
/Med		Louis Ben 4a. Facility Name (If not institution,		nover	45 Ch. Tour		MAY 3	2006		7:30 AM
Exam	iner	WICOMICO NURSING HO	•			r Location of Death		4c. C	ounty of Dea	
Funera			6. Sex 7. Age (In	yrs. last birthday,	SALISBU If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	W I COM I	
Directo		224-60-1668 Usual Residence of Decedent	1 □ MM 2 □ F 94	4 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day 5/29/1	y. Year) 911	Pen	thplace (State or Foreig ountry) nsylvania
yland 10W		10a. State 10b. County	100	. City, Town or L	ocation					10d. Inside City Limits
72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Exarte at Frust be Trailited at	ctor	Maryland Wico	mico	Salisbu	<u>cy</u>					1 ☐ Yes 2 🛣 No
ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Co	ountry?
ath w	ral	611 Tressler I	Drive		21801	L		1	USA	
er de:	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spanic, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Ame Black, Whit	
rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 🕉 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		ì		white
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ould be Mental arked o	To	Norman Bert Sch	noonover			Jennie	Morse			
and and sum	1	19a. Informant's Name/Relationshi David L. Schoor		19b. Maili 1050	ng Address (Street a	and Number or Rura	n Route Numbe	r, City or T	own, State, 2 21163	Zip Code)
s 1 and 2 of Health Item 27		20a. Method of Disposition		Ob. Place of Dispo	osition (Name of	- 1	ate	20c. Loca	tion - City or	Town, State
		1 ☐ Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Specific Control C	3 □Removal from State ecify)		matory or other plac y Cremato		06	Salis	sbury,	MD
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li				_				
Der Imp	1. 1	Paril H. Wor	WADOND CFS	P	501 Snow	Hill Rd.,	Salish	olessi ourv	nonal A	Association 804
/Medical			- FILMENDSCI	1 FAITH	(DE DIAV	Acting	Dic	E.452	-5	Onset and Death
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		1 - For State Registrar	State of Ma	ryland / Depa		lealth and N	/lental Hyg	iene) () eg. No.		158	94
Physic	ian	Decedent's Name (First, Middle, Last, Margaret) K.	Schwar	tz		2. Date of Deal		Yeer	3. Time of 8:15	Death P M
/Med		4a. Facility Name (If not institution, give			T	Location of Death		4c. Count	y of Death		
Exam	mer	1006 Sherwood Ci			Salis	sbury		Wi	comic	:0	
Funera Directo		220-10 42/4	744 o MO C	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 6/4/19	Year) 25	9. Birthp Cour Mar	place (State of ntry) yland	r Foreign
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside Cit	ty Limits
Maryli f sho	ō	Maryland Wicomico	o	Salisbury	7					1 ⊠Yes	2 🗌 No
1 the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	-
th witi	aiD	1006 Sherwood Cir	ccle		2180	04		USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. In Moultal Evanirar must be retilized at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Sp un, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - Americ ck, White, fy: Wh		
nin 72 hou n "natura Muzical E	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NDT use retired	ation during most of work f)	king	16b. Kind of B	Business/In	dustry	
d with giene ar tha	E O	12	4		er/operato	or		Roofin	g con	pany	
War y ratio Z 1 Z 1 2-0000 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "nature!, or traumatic event. In Moultal Exam	To Be C	17. Father's Name (First, Middle, Last) Thomas L. Keating				18. Mother's Nam		Maiden Sumai	me)		
ivical y		19a. Informant's Name/Relationship (T) Joseph Schwartz/s			ng Address (Street)6 Sherwoo						
Dallillore, Definit. Pages 1 ar Department of Hea important: If item any injury or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Disponsion Commetery, creating Salisbury			Date	20c. Location Salis			
permit. Departminents imports any inju		21. Signature of Funeral Service/Licens	60 m	22	Name and Address IOIIOWAY 1 IOI Snow 1	Suneral H Hill Rd.,	lome Prof Salisbu	ession ry, MD	al As 2180	sociat 4	.ion
(e be executed // Medica Examine e pricial ransit e pricial-transit		Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause Decades or Highly that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of):	e ho,	nt	tenle	rl		Onset and D	realii
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w requires that been signed be should be detailed	ed by Pł	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.		oacco use con es 2□No		he cause of di pably 4 🗹	
The law rate has be page 2 shr	Complet						24a. Was a autops perform	Y	Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings a mpletion of ca 2 \(\square\) No	available ause of
cian: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th (Check only on	Θ)			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	27. Manner of Death 1 ☐ Naturel 5 ☐ Pending	1 ☐ Inpatier 28a. Date of Injury (Month, Day	nt 2 □ ER/Outpatier / 28b. Time o /Year) Injury	f 28c. Injur Wor	y at	ome 5 eside 28d. Describe ho			(y)	
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To the Hospital within 24 hours a To the Funeral I completely filled	edicai (29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner state	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	, and due to the corred at the time, d	ause(s) and m ate and place,	anner as s and due to	tated. the cause(s))
To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signe	ed (Month.	Dey, Year)	
		1 / () () /	29h m		201	0267	4	5/4/0	4		
Comp	1	30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type,	Print)	14, 1	also	w).	nd	2181	21
S Regis	tate trar	31. Date filed (Month, Day, Year)		r's Signature	parti						•

		1	For State Registrar	State of Mar	ylanu / i	-		e of D			Reg. No.	2006	15895
Dhyei	oior		. Decedent's Name (First, Middle, Last)							2. Date of De Month	Day	Yeer	3. Time of Death
Physi /Med			RUSSELL LOUIS SNYD					-	and the state of Decate	MAY	03	2006 County of Deat	
Exam	nine		a. Facility Name (If not institution, give s				4b. City,		ocation of Death			WICOMIC	
			31390 DAGSBORO ROA Social Security Number 6. Sex		(In yrs. last bi	rthday)	If Under	DEL 1 Year	MAK If Under 24 Hrs.	8. Date of Bir (Month, Da			hplace (State or Foreign untry)
Funera Directo			214-12-9930 ¹ X	M 2□F	85	Yrs.	Months	Days	Hours Min.	(Month, Da 09-07-	ay, Year) -1920		N VIEW, VA.
show			Jsuel Residence of Decedent 10a. State 10b. County		10c. City, Tow		ation						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the Ma or 28e-f		Director	MD WICOM	ICO	DEI	LMAR	101 7:-	Cado			10a Citiz	zen of What Co	
vith th	i	5	10e. Street and Number				10f. Zip		1075		rog. Omi		
s 23		2	31390 DAGSBORO ROA	D 2. Was Decedent Ev	ver in U.S.	13. W	as Dece		1875 panic Origin? (Sp	ecify Yes or No	o- 1	4. Race - Ame	
and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hydration. Health and Mental Hydration in the state of the		by Funeral	11. Marital Status 1 □ Never Married 2 □ Marned 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates:	10/10-		Yes, spe ☐ Yes		panic Origin? (Sp., Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify:	e, etc. WHITE
72 hour natural		ered p	15. Decedent's Educ (Specify only highest grade	pation	168	(Give k	and of wo	al Occupat rk done du se retired)	<i>iring most of work</i>	king	16b. Kir	nd of Business/	Industry
should be filed within and Mental Hygiene. marked other than imatic event, the Mental Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Mental Control of the Men		Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	ille. D		NAGER			CRE	DIT COM	IPANY
build be filed Mental Hygi arked other		De C	17. Father's Name (First, Middle, Last)						18. Mother's Nam	ө (First, Middle	, Maiden	Sumame)	
Aenta Aenta rked		0	RUSSELL LOUIS SNYD	ER, SR.					EMILY				
2 should I and Men is marke	1		19a. Informant's Name/Relationship (Type	oe, Print)					nd Number or Ru				
and 2 salth n 27 i			DAVID LOUIS SNYDER	- SON	_				DRIVE, SA				
of He of He roth			20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place cemete	of Dispos ery, crem	atory or o	me of other place	1	Date		cation - City or	
Pag ment ent: I			*4 □Donation 5 □Other (Specify)		WICOM					6-2006	SALI	SBURY,	MARYLAND
partition of, interpretation of the partition of Health a importent: If item 27 is eny injury or other tra	90C8		21. Signature of Funeral Service License	reed Blow	Be	70	5 EAS	зт ма	IN STREE	OUNDS FU	SBURY		INC. ND 21804
		1	23a. Part1. Enter the disease, or complishock, or heart failure. List only of	cations that caused to be cause on each line	he death. Do	not ente	r the mod	de of dying	, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
Physicia	-		Immediate Cause (Final disease or condition	META	STAT	, <	SA	20	MA				2 YEARS
/Medica	-		resulting in death) Due to (or as a consequence of):										
*	88	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
uted insit		Examiner	cause. Enter Underlying Cause (Disease or injury										
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eath certi		Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t	☐ Fetal deat		Ectopic p	regnancy			1	23d. Date of de Month	Day Year
the de		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ine or death	3	Other (s	Decity/					
The Cord S, F.O. BOX. The law requires that the death cert the has been signed by the attending		A P	Part II. Other significant conditions co	ntributing to death but	t not resulting	in the ur	nderlying	cause give	n in Part I.	23e. Did	tobacco u	se contribute to	o the cause of death?
uires lisign lid be		d by	ATRIAL F.	BRILLA	T. 0.~	/				1 🗆	Yes 2-	<u>∃N</u> o 3□P	robably 4 Unknown
w req	1	Completed								24a. Wa	s an	24b. Were at	utopsy findings available completion of cause of
The lav		Elo								peri	formed?	death?	2 No
VICION: The certificate rector, pag		0	25. Was case referred to medical						26. Place of Dea				
OI VITAL Physicien: This certifica		0	examiner?	lospital: 1 🗌 Inpatier	nt 2 ERV	Dutpatien	t 3 🗆 D	OA Othe	or: 4 🗆 Nursing H	ome 5 Res	sidence	6 □Other (Spe	ecity)
Attending Physicien: or death. ector: After this certific by the funeral director,		Ilon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		Time of Injury	м	28c. Injury Work	.?	28d. Describe	how injur	y occurred	
DIVISION OT VITAL MECOLDS, othe Hospital or Attending Physicien: The law requirest of the Lours after death. o the Fundenel Director: After this certificate has been signe ompletely tilled in by the funeral director, page 2 should be.		Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location City or To	(Street an own, State	d Number or R)	ural Route Number,
To the Hospital or A within 24 hours after To the Funerel Directorpletely filled in by		edical Ce	(Check only 2 Medical Exam		examination a	ge, death	occurred vestigatio	d at the time n, in my of	e, date and place pinion, death occu	, and due to the irred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
the It nin 24 the It		Medi	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. 29c. License number 29d. Date signed								te signed (Mon	th, Day, Year)	
Valle To To		~	290, Signature and title of contined									•	
CILIH			Physical) (T::==		- 17	60		- / 7	100	
-[1111			30. Name and address of person who c	ompleted cause of de	ath (Item 23a	i) (Type,	erint)	Tree.	57 114	A. L. V	MA	215	65 P
, AT	Cto	10	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		/		,50		7	3	- '
. 37	Sta		MAY 0 5	006	in D	la la	bank						

State of Maryland / Department of Health and Mental Hygiene 🗎 🗎 🖯 15896 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) May 2, 2006 Mary Oshinsky SCHNEIDER Physician 7:15 P. M /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Suburban Hospital Examiner Montgomery Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 3, 1907 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 579–60–9253 **Funeral** 1 ☐ M 2 🔀 F Months Days Washington, DC Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f ahow the Medical Examiner must be notified at Chevy Chase NE Yes 2 □ No MD Montgomery Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20815 U.S.A. #1216 8100 Connecticut Ave. 238 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify: Specify: ģ White 3 ♥ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Charities Charitable Worker 12 ith and Mentai Hygie 27 is marked other r traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental sut; if Itam 27 is marked o Perel Needle William Berenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 Pauline Dr., Chevy Chase, MD 20815 19a. Informant's Name/Relationship (Type, Print) Bernice Breslau / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State B'Nai Israel Cemetery May 4, 2006 Oxon Hill, MD permit. Page Depertment of Important: If any injuryor, once. 4 ☐ Donation 5 ☐ Other Specify)

21. Signature of Furreral Syrvice Liver see 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KN CEPHALXPATHY **Physician** ISCH5MIC Have (disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown LEVKEMIA Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EFVOutpatient 3 DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) Director: After the 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) To the Hospitel or At-within 24 hours after or To the Funaral Direct lilled in by 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
PALL O' BRIEN WYD 8600 OLD GEORGETOWN DD BETHEIDA, MID 20814 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) 2006 MAY 05 PHI BULL Registrar

5/2/06 7:15pm

Schneider

Amended Item 10c per F.D. 05/04/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 0 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** 5:30 2006 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner arroll ykes ville Rida per 8. Date of Birth (Month, Day, Year) Aug. 16, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Wisconsin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days 1 □ M 2 X F Hours 229-16-8469 83 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "neturel", or Items 23e or 28a-1 show other treumetic event, the Macdical Examinar must be notified at 1X Yes 2 □ No Director Carroll 710 Obrecht Road Sykesville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code United States 710 Obrecht Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Itei 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Her Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Petterson Hester Fenney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other treu 259 Logging Trail Road Durango, CO Mark SMith Son 20a. Method of Disposition
1 □ Burial 2X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State May 3 2006 Carroll Crematory Donation 5 Other (Specify) Winfield, MD 22. Name and Address of Facility. Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, MD e of Funeral Service Doense P.A. 21784 Parr . Ent r me disease, or com sho k, or h art failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease y condition resulting i death) tack Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 □ No 3 □ Probably 4 ▼Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred e Hospitel or Attending P 24 hours after death. e Funerel Director: After t Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the Vithin 2 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier 100059943 3,2006 WIL 10 30. Name and address of serson who completed cause of death (Item 23a) (Type, Print) 295 Sprer AR. Svite 30? wasminsty on (Assel MO 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Registrar

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Physi /Me	ician dical	Dorothy Elizabet	h Trott					29, 2006	12:19 A ^M
Exan		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ith	4c. County of Deat	h
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Funera Directo			м 2 XD F 84	Yrs.	Months Days				nplace (State or Foreign untry)
		Usual Residence of Decedent					20	, 1921 WE	aryland
arylar show	-	MD P.G. Courty		ty, Town or Lo owie	cation				10d. Inside City Limits 1 ☐ Yes 2 🔯 No
the M 28a-f cutifie	Funeral Director	10e. Street and Number	nty B	owie	106 7in Code			On Citizen of Mines Co	
with t	Ö				10f. Zip Code		'	0g. Citizen of What Co	untry?
death ms 23	era	12800 9th Street 11. Marital Status	12. Was Decedent Ever in U	I.S. 13. V	20726 Vas Decedent of F	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	U.S.A. 14. Race - Ame	
or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give		Yes, specify Cub		rto Rican, etc.)	Black, White	
ING 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. Ind other than "neturel", or Items 23a or 28a-f show event, the Medical Evancing must be notified at	Completed by	3 Widowed 4 □ Divorced	Year or Dates:					Specify: Whi	
15-1-15-1-15-1-15-1-15-1-15-1-15-1-15-	lete	15. Decedent's Edu (Specify only highest grad	ication le completed)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of w	orking	16b. Kind of Business/	ndustry
withii iene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	o)		Home	
in Hyg other	BeC	17. Father's Name (First, Middle, Last)		IICAIR	AIRMICI.	18. Mother's Na	ame (First, Middle, M	110110	
arylan should be and Mental markad o	To E	Jas J. Berbig				Doro	thy M. Kir	ng	
V 0 = 0	1	19a. Informant's Name/Relationship (T)	(Pe, Print) In-Law	19b. Mailin	g Address (Street	and Number or F	Rural Route Number	City or Town, State, Z	ip Code)
C = 44 F		Constance L. Trott	(Daughter-	1970	Wild_Tur	key Tra	11. Huntii	ngtown, MD	20639
altimore, mit. Pages 1 a partment of Hes portent: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 F	tellioval livili State		sition (Name of natory or other pla		, 4,	20c. Location - City or	
Baltimol parmit. Pages Department of Importent: If it any injury or or	_	' 4 □ Donation 5 □ Other (Specify)		e Crema				Clinton, Ma L Home Calv	
Darmi Parmi Depar Impo	8000	Manage W. L	ee					d., Owings,	
S760, ata be executed Wedica Thysician and the burial-transit	al	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	v A Suguence of):			DISE		Interval Batween Onset and Death
8760 ata be a nysician he buriz	ical	l	d						
.O. BOX 61 the death certific y the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	ıl death 3□	Ectopic pregnance Other (specify)	у		23d. Date of deli Month	very Day Year
ecords, P. law requires that as been signed b	by	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying cause giv	ren in Part I.		pacco use contribute to	
w require	Completed	sulmonan	Anis.	AIL	itic -	Stuni	1 24a. Was ar	24b. Were aut	opsy findings available
VITAI REC sician: The law s certificate has b lirector, page 2 s	ошо	comedice 3	James I Lei	Ima	Anim	256	autops	y prior to c ned? death?	ompletion of cause of
	a)	25. Was case referred to medical	Cell ()		711000	26. Place of De	ath (Check only one	1 Yes	212000
Of V Physic this ce	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Oth	ner: 4 Nursing	Home 5 Reside	nce 6 Other (Spec	ify)
DIVISION Of lor Attending Phy- after death. Director: After this in by the funeral d		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe ho	w injury occurred	
ISIO ktendi death. ctor: A y the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not be	200 Place of Injury At la	ama farm star		Yes 2 □ No	29f Leasting (St	roots and Murahaman D.	ALD ALL MAN
DIVI lor A after Direc	ertif	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	fy)	ет, тастогу, оптсе		City or Town	reet and Number or Ru , State)	rai Houte Number,
DIVISION Of VIta Votte Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	O	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death	occurred at the tir	me, date and place	e, and due to the ca	use(s) and manner as	stated.
he Ho n 24 t he Fu sletely	edicai	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my o	ppinion, death occ	urred at the time, da	ate and place, and due	to the cause(s)
To the To the Comp	Ž	29b. Signature and title of certifier	nother	7	29c. Licens			Od. Date signed (Month	Day, Year)
		•			10-	254:	٠ ٠	-11 -110	D
		30. Name and address of person who ca							
ĮV.	State	Mukesh Mathur, M.J 31. Date filed (Month, Day, Year)	D. 110 Hospi	tal Roa			rick, Mary	land 20678	
Regi		MAY -	3 2005 Brace	w K	Coule	9			

			For State	State of Ma	aryland / Depa	rtment of H			2000	15901
			Registrar 1. Decedent's Name (First, Middle, Last)		inouto or i		Reg. I	NOL U U U	3. Time of Death
	Physici	an		obert	Thompson	. Jr.			b 2006	8 AMM
	/Medic Examin		4a. Facility Name (If not institution, give		THOMPSON		Location of Death		4c. County of Death	
	LAdiiiii	e.	Calvert Memorial				Frederic		Calver	+
	Funeral		5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth (Month, Day, Yea	9. Birtho	lace (State or Foreign
L	Director		138-42-1012	M 2□F	56Yrs.	Months Days	Hours Min.		40=0	Jersey
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loc	ation				
	anyla shov	7	,	_	Toc. City, fown of Edi				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M 28a-f	Director	MD Calver	Ľ		Sunder	Tano	10-	011111111111111111111111111111111111111	
	with		10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry /
	eath	Funeral	2551 Sharon Circ	le 12. Was Decedent B	Ever in II S 13 V	206	89 spanic Origin? (Spec	ify Vac or No-	USA 14. Race - Americ	an Indian
	Iter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X N	lf If	Yes, specify Cuba	n, Mexican, Puerto R	ican, etc.)	Black, White,	
99	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examinar must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify: wh	ite
0	72 hours "natural', dical Exa	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occupa	ation during most of working	16b.	. Kind of Business/Inc	dustry
21	f within 72 ho liene. r than "natul Ine Modical	nple	Elementary/Secondary (0-12)	College (1-4or 5	life. D	O NOT use retired,)	′		
21		Con		4	route	salesma			ood servi	ces
pu		e	17. Father's Name (First, Middle, Last)				18. Mother's Name (
<u>}</u>	should be ind Mental s marked c umatic ave	은	James Robert Thom		201 44 11		Elizabeth			
Maryland 21215-0036	C 60 = 68	10	19a. Informant's Name/Relationship (T)			•	and Number or Rural			Code)
	1 and Health am 27 other tr		Deborah A. Thomps 20a. Method of Disposition	on, wire	20b. Place of Dispos	sition (Name of	ircle, Sur		Location - City or To	wn. State
DOI	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)			atory or other place				
Baltimore,		1	21. Signature of Funeral Service Licens			Name and Addres	atory 5-11	-06 A	lexandria,	, VA
B	permit. Departr Importa any inja	0 3	1 William 5	5. 6 h			neral Home	P.A.,	Owings. M	20736
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused	the death. Do not ente					Approximate Interval Between
	Pnysician :	Š	Immediate Cause (Final disease or condition		105156	SNID 577	RCE INIC	O DISE	ASE)	Onset and Death
	/Medical		resulting in death)		a consequence of):	200 01.	THE TIVE	2 0 100	,,,,,	
	Examiner		Sequentially list conditions,	0.	- 10					
	sit s	inei	Lany, leauning to limit adiate cause. Enter Underlying Cause (Disease or injury	One to (or as t	a consequence of):-					
	and I-tran	Examine	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
8760,	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit									
687	ficate phys s the	edical		d						
Вох	eath certific attending p I for use as	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of delive	rv
m.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
0	that the ded by the detached	Physician/M	9 Unknown	9□ Unknown						
S, P	es tha igned be de	ру Р	Part II. Other significant conditions con	_	-	derlying cause give	en in Part I.	23e. Did tobacc	o use contribute to th	e cause of death?
ord	v require been si should t		AORTIC STENOS	15 , Ar	VEMIA,			1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
Vital Records,	law as b 2 s	ompleted	GALL BIN	poer oi	SEASE			24a. Was an autopsy	24b. Were autop	osy findings available
<u> </u>	That at a se	Соп						performed?	death?	2□ No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death /	Check only one)		
of	Physician: this certific ral director,	P	1 195 250110	lospital: 1 atie			4 Nursing Home		6 ☐ Other (Specify)
n C		lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	28c. Injury Work M 1 □ Y	:?	d. Describe how in	jury occurred	
isi	l or Attending after death. Diractor: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Inju	ıry - At home, farm, stre		fes 2 □No	f Location (Street	and Number or Rura	Pouto Number
Division	lor A after Dirac	Certificati	4 Homicide determined	building, etc	(Specify)	et, ractory, office	20	City or Town, Sta		noute Number,
	e Hospital 24 hours a a Funeral D letely filled	aC	29a. Certifier Lecertifying Phy	sician: To the best of	of my knowledge, death	occurred at the tim	e, date and place, an	d due to the cause	(s) and manner as st	ated.
	T 4 T W	edical	(Check only 2 Medical Exami one)	ner: On the basis of and manner sta	examination and/or inv	estigation, in my op	pinion, death occurred	at the time, date a	ind place, and due to	the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	1 1	/ -	29c. License	number	29d. E	Date signed (Month, L	Day, Year)
			Homes (1)	Mouch	7, MO	D50	233		5/7/0	76
	10		30. Name and address of person who co	empleted cause of de	eath (Item 23a) (Type, F	rint)		-0 -1 -1	en HOLDICK	MO
	14		Glynis A Moo	dy, MO	110 HOSF	ITAL DR,	SUITE 314,	ALINCE "		20678
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	and (Item 23a) (Type, F	Spelle 3				
	ricgisti	en -	MAY	LUUU	MANAGE NO					

			1 - For State Registrar	State of Maryla		artment o		nd Mental Hy	giene Reg. No.	2005	15902
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) William Talle	У		4h Cib. To	Landing of	2. Date of De Month May	Day 03		3. Time of Death
F	Examir uneral	er	4a. Facility Name (If not institution, give s Prince Gaorge 5. Social Security Number 6. Sep	Medical Co	s. last birthday)	Che If Under 1 Ye	verly sar it ones 24 ys Hours			9. Birthp	George place (State or Foreign Th Carolin
	Moye J-	tor	248-54-3415 1 1 1 1 1 1 1 1 1	//	0 Yrs. City, Town or Lo Washi			3/15	/36_		10d. Inside City Limits
th with the	23a or 28i	ai Direc	10e. Street and Number 1477 Morris Ro				0020		U	en of What Cour	ntry?
5-0036 72 hours after death with the Maryland	Exactinating	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 10 IN 19 If Yes, Give 1/1.	v.s. /31/57 3/55	Was Decedent If Yes, specify 0 1 ☐ Yes 20	of Hispanic Origin Cuban, Mexican, No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	p- 1	4. Race - Americ Black, White, Specify: B1	
2121	nysiere. od other than "naturel", or liems 23a or 28a-f ehow event, the Madical Exarch ar maal be rudified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	dent's Usual Od kind of work do DO NOT use re Labor	ne during most o tired)	of working	16b. Kin	of Business/In	
D # 1	marked oth	To Be (17. Father's Name (First, Middle, Last) Albert Talley				На	s Name (First, Middle ttie San	ders	,	
is 1 and 2 st	Item 27 is n		19a. Informant's Name/Relationship (Ty, Alice Talley 20a. Method of Disposition	wife 20b.	147		is Roa	or Rural Route Numb d SE Was Date	hing		20020
Baltimore,	Department of nearing and works important; if Item 27 is marked any injury or other traumatic events.		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		Mt Ol	ive 2. Name and Ad	ddress of Facility	/10/06 Snead Mo	rtua	shingtory ry Ser	on,DC vice,P.A. elliville
	/sician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	ath. Do not ent	ter the mode of	dying, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
	physician and physician and stee prival-transit	ilcal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection of	equence of):	4		FIEN			
P.O. Box 61	by the attending pt tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregna Other (specify	incy)		23	3d. Date of delive Month	ery Day Year
ords, P.	been signed by should be deta	by	Part II. Other significant conditions con	ntnbuting to death but not re	esulting in the u	nderlying cause	given in Part I.			e contribute to th	he cause of death?
al Reco	55 CA	Completed						24a. Was auto perio 1 🗌 Yes		prior to con death?	psy findings available mpletion of cause of
Division of Vital Records, alor Attending Physician: The law requires tales clean	the Euneral Disco. After this certificate ha mpletely filled in by the funeral director, page	ıtlon: To Be	25. Was case referred to medical examiner? 1	lospital: 1 □ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. l	Other	f Death Check only or ing Home 5 Resi	dence 6		(v
Divisi	I Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str hify)	eet, factory, offi	се	28f. Location (City or To		Number or Rura	al Route Number,
Div To the Hospital or within 24 hours after	To the Funeral Dir	Medical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my kr ner: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the	e time, date and i ny opinion, death	place, and due to the occurred at the time,	cause(s) a date and p	ind manner as st place, and due to	lated. the cause(s)
	To the	¥	29b. Signature and title of contifier	> $<$		1	ense number	182		signed (Month,	
			30. Name an address of person who co DR . DONALD GE 31. Date filed (Month, Day, Year) MAY 0 5 200	mpleted cause of death (Ite	3001 410	SPITAL	Doc	82 CHEVA	ERLY,	MD 2	10785
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 5 200	32 Registrar's Sign	nature	de			,		1

			State of Manyland / Denominant of Lleel		-		15003
			1- State of Maryland / Department of Heal Certificate of Dea		ıtaı mygler Reg. i		10000
	-		Decedent's Name (First, Middle, Last)		Date of Death	40.	3. Time of Death
	Physici /Medic		Joseph S. Triglia,	$\sum r$.	5 0	2 2006	15 . 5
1	Examin	er	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loca Coastal Hospice At the Lake Salisbur		·	County of Death	CO
	Funeral Director		214-12-6446 18 M 2 F 94 Yrs. Months Days Ho	ours Min. (Date of Birth Month, Day, Yea t. 27,	ar) Coui	place (State or Foreign htry) York
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	the Ma 28a-f	Funeral Director	DE Sussex Delmar 10e. Street and Number 10f. Zip Code		10a. 0	Citizen of What Cour	1 ☐ Yes 2 🖾 No
	ath with	rai Di	36999 St. George Road 19940		U	J.S.A.	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28a-f ehow empty injury or other traumatic event, the Madical Examinar must be notified at ODGs.	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, specify Cuban, Me If Yes, Give Year or Dates:	ic Origin? (Specify exican, Puerto Rica	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify:	
215-0	thin 72 ho e. en "natur Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16b.	Kind of Business/In	dustry
2	y gier t,	ပ္ပ	8 Owner & Operato			ucking Co	mpany
Maryland	lid be fill fental H ked oth	To Be		Mother's Name <i>(Fir</i> [aria Saco		en Sumame)	
lary	and N sand N s mar		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and N</i>	lumber or Rural Ro	ute Number, City	y or Town, State, Zip	Code)
e,	f and fealth om 27		Theresa T. Trader (Daughter) 2994 Connelly M 20a. Method of Disposition 20b. Place of Disposition (Name of	iill Rd.	Delmar,		<u> </u>
Baltimore,	Pages nent of H int: If Ite iry or ot		1 \(\mathbb{B}\) Burial 2 \(\subseteq \text{Cremation} \) 3 \(\subseteq \text{Removal from State} \) 4 \(\subseteq \text{Donation} \) 5 \(\subseteq \text{Other (Specify)} \) St. Stephens Cemeters	1		Delmar,	
Balti	permit. Departn Importa eny inju		21. Signature of Funeral Service Licensee 22. Name and Address of Short Funera 13 E. Grove	Facility 1 Home		19940	DOTAWATO
	Physician /Medical Examiner pricin and pricing fransit	Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or hear failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	MCO-C	piratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e attending phys id for use as the	Physician/Medical	d	-		23d. Date of delive	Day Year
rds,	w requires that the been signed by th should be deteche	ed by	Part II. Other significant community continuing to death but not resulting in the briderying cause given in i	rait i.	. /		ably 4 Unknown
Division of Vital Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed? 1 Yes 2211	prior to co death?	psy findings available mpletion of cause of
#	cian sertif ector	Be	examiner?	Place of Death (Ch	eck only one)		
n of \	ing Physician: After this certific uneral director,	lon: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	28d.	5 Residence Describe how in	6 □Other (Specifically occurred	v)
Divisio	To the Hospital or Attending Phys within 24 hours alter death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. I	Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
	Hospitu 24 hours Funeral stely filler	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, da (Check only one) American Physician: To the best of my knowledge, death occurred at the time, da (Check only one)	ate and place, and on, death occurred at	due to the cause the time, date a	(s) and manner as s and place, and due to	ated. the cause(s)
	of the	Me	29b Signature and title of certifier 29c. License num	nber	29d. E	Date signed (Month,	Day, Year)
	F 3 F ŏ		NZE COLUMB NZE	278		5-3-0	6
-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1715	(11		1802
			31 Date filed (Month Day Year) 32 Ministrar's Signature	0×1/33	Selish), MIN V	10-1
	Sta Registr	te ar	29b. Arginature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) MAY 0 5 2006 32. Registrar's Signature			1	

State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6_ 3. Time of Death May 02, **Physician** 2006 4:00 p M Robert L. Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1X M 2□F Yrs. 99 578-32-9829 24,1907 Indiana January Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itama 23s or 28a-1 show amportant: If item 27 is marked other than "natural; or Itama 23s or 28a-1 show any Injuryon that the mortified at once. 10a State 10b. Count 10d. Inside City Limits Yes 2 No Directo Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code 301 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∑∑Xes 2 ☐ No WWII If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify:White þ 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Latin Amer Allairs 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. State Department 5+ Asst. Sec. of State 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Luther Adair Thompson Pearl May Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Thompson/Son 419 Russell Avenue, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 05-05-2006 ' 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Tyneral Sev. 4: Licensee Brentwood, MD Fort Lincoln Crematory 22. Name and Address of FacilitySimple Tribute, 1040 Rockville ant Pike, Rockville, MD 20857 23a. Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 das disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of? Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Hospital or Attending Pt 24 hours after death. Funeral Diractor: After th

within 24 hours a To the Funeral C

To the

Division of Vital Records, P.O. Box 68760

Funeral

Director

with the Maryland

Baltimore, Maryland 21215-0036

icie Dementia 25. Was case referred to medical

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 ☑No 1 ☐ Yes 1 Tyes

1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending

28a. Date of Injury (Month, Day Year)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

28l. Location (Street and Number or Rural Route Number, City or Town, State)

I PRaliet Bisselele

29c. License number 104115

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. ROBERT BIRSCHBALH 12

State Registrar 31. Date filed (Month, Day, Year) 05 2006

investigation

6 Could not be determined

06-02950 Stephen E. Unthank

Please Type or Print in Black Indelible Ink

Stephen E. Ont		1- For State Registrar		of Marylan	•	tificate o		na wichta	R	leg. No.	006 1597
Physic Medical Exam		1. Decedent's Nam	e (First, Middle,La Edgar Ui	,					2. Date of Dea Month May 1, 20	Day Year	3. Time of Death 77
		4a. Facility Name (if not institution, gi	ve street and numb	er)	T	4b. City, Town,	or Location of D		4c. County o	
Funeral		5. Social Security I			Age (In yrs. Ia	ast birthday)	Lanham If Under 1 Y	ear If Under 2	24Hrs. 8. Date of Bi	Prince G	9. Birthplace (State or
Director		313-52-2		∑M 2_F	58	Yrs		ays Hours	Min. 11/24		Foreign Country) CA
v any		10a. State	10b. County		10c. City,	Town or Local	tion				10d. Inside City Limits
yland -f shov once.	tor	MD 10e. Street and Nu	Prince (Georges	Bowi	.e	1405 7: 0 1				1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director		exis Driv	7.0			10f. Zip Code 20720			10g. Citizen of Wha	at Country?
h with 1	Funeral	11. Marital Status		12. Was Deced			as Decedent of I		? (Specify Yes or No uerto Rican, etc.)		American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Nental Hygiene Important: If item 27 is marked other than "natural", or items 23a, or 28a-f sho righury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	3 Widowed		1 X Yes	² No 67-177	1	Yes 2X	No specify:		Specify: V	
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212 nould be d Ment is mark	TO B	19a. Informant's Na	ame/Relationship (Type, Print)	-,_	19b. Mailin	g Address (Str		r or Rural Route Nur		, State, Zip Code)
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Baltimore, permit. Pages I ar Department of He Important: If ite		4 Donation 5 21. Signature of Fu			Ple	asant 22.1	HILL Cer Name and Addre	netery (ess of Facility)5/08/2006 Robert E.	Evans Fu	neral Home
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6876 ertifica ding ph	ian/M	23b. Was decedent past 12 months		1 Live birth		2 Fe	tal death 3	Ectopic pr	egnancy	23d. Date of d Month	Day Year
Box 687 e death certific the attending i ed for use as th	Physician/	1 Yes 2	No 9 Unknow		t at time of dea	^{atri} 5 Ot	her (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	by Pt	Part II. Other sign	ficant conditions	contributing to de	eath but not re	sulting in the u	underlying cause	given in Part I.			ute to the cause of death?
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D Hospital 24 hours Funeral		4 Homicide 29a Certifier	determine	(0,000)		a death again					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2			xamination ar				, and due to the caus red at the time, date		
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		30. Name and add		completed cause of sistant Medica	0	,	nn Street, B	altimore, Mi	D 21201		
S Regis	tate	31. Date filed (Mor	Y 0 4 20	Regis	strar's Signatu	re done	(K)	-			

			For State Registrar	State of Ma	aryland /		artment rtificate			ınd M	ental Hy	giene Reg. No	006		906
	Physici /Medic		1. Decedent's Name (First, Middle, Last Violet E•)	-					2. Date of De Month	Day	Yeer 2000	3. Time o	f Death A M
	Examir		4a. Facility Name (If not institution, give Calvert Manor H		re Cei	nt.	Ri	sin	Location o	n			ounty of Death		
	Funeral Director		5. Social Security Number 6. Se 196-24-3512 15 Usual Residence of Decedent	х 7. Ag	93	birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da 12-3-	1912	9. Birthp Cour Newt	lace (State stry) OWN,	
	Maryland a-f show	ctor	10a. State 10b. County MD Cecil		10c. City, To								1	0d. Inside C	ity Limits
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be incitified at Once.	To Be Completed by Funeral Director	10e. Street and Number 1881 Telegra 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad Elementary Secondary (0-12) 17. Father's Name (First, Middle, Last) Thomas C. J. 19a. Informant's Name/Relationship (7) Rita M. Marra 20a. Method of Disposition 18 Burial 2 Cremation 3 Secondary (1900)	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: Ication College (1-4or 5 Ones rpe, Print)	+) 16	6a. Decec (Give life, L HOM 9b. Mailir 111	Was Deced If Yes, spec It Yes 2 Ident's Usua Ikind of wor DO NOT Usu It Emak It Le Sition (Nam Inatory or G	191. ent of His ent of	spanic Origin, Mexican Specify: tition uring most 18. Mother Ar and Numbe Bride	of working of working of the second of the s	(First, Middle larie Route Numb	U 16b. Kinc 16b. Kinc Maiden S. Powe er, City or 1 ttin 20c. Loca	Home	ite dustry Code) PA 19 wn, State	9362
Baltir	permit. Pag Department Important: I any injury o		21. Signature Pineral Service Ligens 23a. Part1. Enter the disease, or comp	May		E 0	. Name and	Addres	s of Facility	lin	Oxf s Fund	ord, eral	PA 19 Home,	363	
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			partment of Health and Nertificate of Death		ne No.2006 [590]
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) HAROLD EUGENE WILLIAMS 4a. Fecility Name (If not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster	4	2006 3. Time of Death 8:28 P M 4c. County of Death Carrol 1
Funeral Director		5. Social Security Number 213-52-9264 Usual Residence of Decedent		8. Date of Birth (Month, Day, Yea May 3, 19	a Bish-less (State of Feet
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Physician /Medical Examiner physicien and p	ical Examiner	23a. Part. Enter the disease of complications that caused the death. Do not enshock, or head fairfire. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	eter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
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To the complete compl	W	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type	29c. License number Print) Print)	37 5	ate signed (Month, Day, Year) 13 (06) 2012 (157)
Sta Registr		31. Discilled (Nonth, Day, Year) MAY 0 4 2006 32. Registrar's Signature	bearle)		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month O5 **Physician** : 30 A M 2006 ahlon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner IKton. Hospita Ceci コーロラ If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). 63 Yrs. 8. Date of Birth (Month, Day, 02 - 2 Birthplace (State or Foreign Country) 5. Social Security Number 6. Se: **Funeral** Months Days Hours 12M 2□ F 213-40-217 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "naturel", or Items 23e or 28e-f show Nes 2 No EIKton Director eci 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code States 21921 Michaels nited Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) 10 Truck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumetic event ang. To Be Ward Bertram 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28 IKton, mo Ward Court. dna 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) boow ni. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Strano + Feeley Family Funeral 14 635 Churchmans Rd. Newark. DE 19702 elevere 635 Churchmans wown Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** YUUY disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Tes 2 No Be Completed this certificate has been 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 🗆 No 1 Yes or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 **N**o 2 ER/Outpatient Certification: To 1 Yes 1 🔲 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? . Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Philip Hequembourg Wing

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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217-72-4085 1/3 M 3 38 Vis Months Days 100x1 Months Days	1		4a. Facility Name (if not insti	tution, giv	e street and nu	imber)		1	-		ocation of (<u> </u>		-		
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20. Were not placed or Disposition Date 20c Location - City or Town, Stelle 20c Location City or Tow	r death with the N or items 23a or must be notified	Funeral	11. Marital Status 1 Never Married 2	Married	12. Was Ded Armed F 1 Yes	orces?		If Ye	s Decedent of es, specify C	of Hispa Juban, M	/lexican, P				14. Race - / White, e	etc.	lian, Black,
20. Were not placed or Disposition Date 20c Location - City or Town, Stelle 20c Location City or Tow	36 nn 72 hours af tan "natural" dical Examina		15. Decedent's Education (Elementary/Secondary (0	Specify or	or Dates: ly highest grad	de completed)	- dı	ecedent uring mo	's Usual Occ ost of working	cupation g life. D	n (Give kin				. Kind of Busir	ness/Industry	
20. Method of Disposition Date 20c Location - City or Town, Stelle	215-00; e filed with tal Hygiene ked other th	ပေ၂	17 Father's Name (First, Mid		Wing		Tax	<u>xie</u>	Cab O	18	.Mother's I	,		, Maide	en Surname)	pany	-
22 Sport are of Fusions Service Licopees Name and Address of Facility One Shuncral Home, P.A. 1317 Cokesbury Road, Abingaon, Maryland 21009	MD Z1. 2 should b h and Men 27 is marl		19a. Informant's Name/Relat	onship (T	ype, Print)					Street a	nd Numbe	er or Rur	al Route N	umber,	City or Town,		
Post Company Part	more, Pages I and ent of Healt nt: If item		1 Burial 2 Crem		Removal fr	om State	b. Place of cremator	Disposi y or oth	tion (Name o er place)	of ceme	tery,	(Date	200	Location - C	ity or Town,	State
Physician (Medical Sxaminer) Variety Part Enter the disease, or complicate, which and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Lateroly one cause on earth of the enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Lateroly one cause on earth of the enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. Lateroly one cause on earth of the ear	Baltur permit. It Departme Importa	1			MAL	/		Mod	ame and Ad	dress o	f Facility	Home	P. 7	١			
The part of the past is presented to medical examiner? The part of the past is presented to medical examiner? The past is presented to medical examiner The past is presented to the past is presented to the past is presented to the past is presented to the past is presented to the pas	Sxaminer lisiu	Examiner	or condition resulting in dea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiat events resulting in death) L	b. use ed c.	Due to (or as a Dilated Due to (or as a Due to (or as a Due to (or as a	consequence cardio consequence consequence	e of): megaly e of): of):	7 100	ME ass	5 5/	21.106.9	TTP					Death
25. Was case referred to medical examiner? 1	box 60/00, death certificate be e the attending physicia dor use as the buria	sician/N	IF FEMALE: 23b. Was decedent pregnant past 12 months?		23c. If yes, 1 Live to	outcome of pr pirth ant at time of	egnancy 2	Fet	al death	3	1		у	2			Year
25. Was case referred to medical examiner? 1	requires that the been signed by tould be detached	≱	Part II. Other significant co	nditions	contributing to	o death but no	t resulting	in the u	nderlying ca	use give	en in Part I	_	1 Yo	es 2 [s an	No 3 24b. We	Probably are autopsy fi	Unknown
Natural 5 Pending Investigation 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. (Specify) (Spe			25. Was case referred to me	dical I					26.6	Place of	Death (C	heck onl	perf 1 🗸 Yes	formed?	? dea	ath?	
1	Physicia er this cer eral direct	2 2	1 ✓ Yes 2 No	F					3 DOA	Ot	her ₄ N	lursing l	Home 5				· · · · · · · · · · · · · · · · · · ·
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. May 14, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	- # · ^ #	cation:	1 X Natural 5 2 Accident	nvestigati	on				1	Yes	s 2 N	0					to Number City
and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. May 14, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Hospital or 24 hours afte Funeral Dir		4 Homicide 29a Certifier	letermine	(Specify)							ı,	or Town,	State)			te Number, City
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Registrar MAY 1 9 2006 Viscon & April 1			31. Date filed (Month, Day, Y	ear)	32/ R			enn S	ereet, Ba	шпог	e, IVID 2	1201					

			1 - For State Registrar	State of M	larylar		artmen rtificate			ind M		giene Reg. No.2	106	15910
	Physici /Medi		Decedent's Name (First, Middle, Las DORIS	V		W	ILES				2. Date of De Month April	Day	Year 06	3. Time of Death 5:38 P M
7	Examir		4a. Facility Name (If not institution, give 10811 Old Nation	nal Pik	2		New	Ma	Location of			Fre	ty of Death deric	
	Funeral Director		5. Social Security Number 6. Social Security Number 212–38–9853 1 Usual Residence of Decedent	9X 7. A. □M 2【X]F	ge (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da NOV . 3	th iy, Year) , 1938		place (State or Foreign ntry) 11and
	he Maryland 28a-f ehow cutilied at	Director	10a. State 10b. County Maryland Freder	rick	10c. Ci	New	Marke							0d. Inside City Limits 1 ☐ Yes 2 No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependent of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or itema 23e or 28e-1 show any follury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Dir	108.11 Old Nat 1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	?		Nas Deced f Yes, spec	2 lent of Hi	1774 spanic Orig n, Mexican, Specify:	in? (Spe Puerto l	cify Yes or No Rican, etc.)	Unit - 14. Ra - Spec	ed S ace - Americ ack, White,	tates can Indian,
Maryland 21215-0036	within 72 hou ane. than "natural he Medical E	Completed !	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1.2	ucation	5+)	life. l	lent's Usua kind of wor DO NOT us Home—1	k done d e retired)	uring most	of workir	ng	16b. Kind of		dustry
yland 2	ould be filed Mental Hygis arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles		Sa	anbower		шаке	18. Mother	's Name 'ene	,	own Maiden Suma Aushern	ime)	
e, Mar	1 and 2 sho Health and Iom 27 Is my other traums		19a. Informant's Name/Relationship (7) Thomas E. Wiles 20a. Method of Disposition	ype, Print) / Husban		1081	1 01d	Nat	ional	Pik		er, City or Town Market 20c. Location	, MD	21774
Baltimore,	irmit. Pages apertment of iportant: If it iy Injury or o		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen)		Place of Dispo cemetery, cren sthaver	Mem.	Gard	len 05	5/04,	/2006	Freder: Funeral	ick,Ma	ryland
8			23a. Part1 Fifter the disease, or comp shops or heart failure. List only of Immediate Cause (Final	ofications that cause one cause on each I	me.	th. Do not ente	621 O	poss	umtown , such as c	n Pi ardiac oi	ke/ Fre	ederick rest,		
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as		STATIC quence of):	: B	ow.	EL_	CA	ncino	DM A		nowTHS
8760,	ate be executed thysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
P.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Feta	if death 3	Ectopic pre						ate of delive onth	ory Day Year
	w requires that I been signed by should be detai	þ	Part II. Other significant conditions co	entributing to death b	out not res	ulting in the un	iderlying ca	iuse give	n in Part I.					e cause of death?
al Reco	n: The law requicate has been r, page 2 shouk	Completed									24a. Was autop perfor 1 Tyes	rmed?	Were autop prior to con death? 1 \(\text{Yes} \)	osy findings available inpletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	Hospital: 1		ER/Outpatient 28b. Time of Injury		A Other	4 ☐ Nurs	sing Hom		ne) lence 6 ⊡Ot now injury occu		')
Divis	Ital or Atternis after dearester dearester dearester filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	c. (Specif	(y) 					City or Tow	m, State)		l Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	ledical	one)	rsician: To the best iner: On the basis of and manner st	t examina	owledge, death ation and/or inv	estigation,	in my opi	nion, death	place, ai occurre	d at the time, o	date and place,	and due to	the cause(s)
	or with	Σ	29b. Signature and title of conting			na		License	number 6 49	9		29d. Date signe		
	Sta	te.	30. Name and address of person who control Ronald E. Mill 31. Date filed (Month, Day, Year) MAY 0 3 2	ler / 4 Cu	11we1	1 Dr.	/ Mour	nt A:	iry, N	Mary.	land	21771		
	Registr		MAY 0 3 2	306 100	ر مع	15. A.	coll)							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Month Wallace Physician Mar Elizabeth 2000 7:52 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 210 Mason Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2X F Yrs. 220-40-4263 99 Director Maryland Apr 3, 1907 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits Item 27 is marked other than "natural", or frame 23a or 28a-f show other traumatic event, the Modical Examinational tennolities at Prince Frederick 1 ☐ Yes 2 No Director MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Mason Road 20678 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any lajury or other traumatic event, the Medical Exercited PAGE. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Nursing Home** Nurse's Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Saunders Thomas Kyler ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice H. ljames/Daughter P.O. Box 1363 Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/05/06 Sunderland, MD Calvary United Apostolic Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Sewell Funeral Home Gladys a. Servell 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner he SCLRO 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown tate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 🗌 Yes 20 No 2 No To the Hospitel or Attending Physician: After this certification, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2€No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 033123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. Prince Frederick, 20678 32. Registras Signature 31. Date filed (Month, Day, Year) State 4 2005 Registrar

			1 = For State Registrar	State of Marylar			f Health and of Death		Reg. No.	2006	15	912
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of D Month	eath Day	Year	3. Time o	
	/Medic		Kathryn F. Walk					May	2,	2006	5:25	рм
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Tow	n, or Location of Dea	th	4c. (County of Death		
			Suburban Hospital 5. Social Security Number 6. Se		last birthday)	Bethe If Under 1 Ye		S. 8. Date of B	rth	Montgom	ery	or Foreign
	Funeral Director		,	M 2√2 F 9.2	Yrs.	Months Da			ay, Year)	Cour	ntry)	-
			Usual Residence of Decedent	92				000. 1	1, 13	TO New	Jerse	<u>зу</u>
	nylan ihow	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside C	
	Sa-f-	çţ	Maryland Montgom	nery K	ensing	ton					1 □ Yes	21 <u>X</u> No
	ih th	Director	10e. Street and Number			10f. Zip Cod			10g. Citiz	en of What Cour	ntry?	
	72 hours after death with the Maryland natural', or items 23a or 28s-f ehow dical Exartinet the rudified at	120	3618 Littledale R			2089				USA		
	er de	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or N nto Rican, etc.)	0- 1	 Race - Americ Black, White, 		
36	II, or	by	3 Widowed 4 Divorced	1 ∐ Yes 2 ☑No If Yes, Give Year or Dates:		1□Yes 2√x	No Specify:			SpecifyWhite	е	
5-0036	72 hours "natural", dical Exp	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc	cupation		16b. Kin	d of Business/In	dustry	
215	- 8	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work do DO NOT use re	one during most of wo stired)	orking			·	
21	should be filed within a Mental Hygiene. marked other then matic event, Ine M	E O	12		Exe	ecutive	Secretary	7		Offic	ce	
	be filled tal Hygi d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	e, Maiden S	Sumame)		
<u> a</u>	should be ind Mental marked o umatic eve	10	Frank Walker				Kather	ine Wri	ght			
Maryland	2 sho and Is ma		19a. Informant's Name/Relationship (7	•		-	reet and Number or R				,	
-	of Health Item 27		Jon S. Burke/ Nie		_		rence Driv					1
ore	nit. Pages 1 and 2 should be filed within ortainent of Health and Mental Hygiene. ortainert if item 27 is marked other them injury or other traumatic event, the Me.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐		Place of Dispo cemetery, crei	esition (Name o natory or other	place)	Date	20c. Loc	ation - City or To	wn, State	
Ë	tant:		4 □ Donation 5 □ Other (Specify) Met		an Cremat		2006	Alex	andria,	Virgi	nia
Baltimore	permit. Pages Department of t Important: If ite eny injury or of once.		21. Signature of Funeral Service Liven:	wfarky	Fi	P. Name and Adrancis Cancis OO Univ	dress of Facility. J. Collins ersity Bly	Funera	l Hom ilver	e Inc. Spring,	MD 2	0901
8760,	Physician and // // // // // // // // // // // // //	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect to Due to (or a consect to Due to Due to (or a consect to Due to Due to (or a consect to Due to Due to (or a consect to Due to	tine quence of):	al fear	ailone n- fai ne poln	Ivne	dis	ear.	Interval Bet Onset and	
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	Ectopic pregna Other (specify			23	3d. Date of delive	,	Year
Records, P	uires that signed b d be det	þ	Part II. Other significant conditions co	entributing to death but not res	-	nderlying cause	given in Part I.	_	tobacco us Yes 2 □	e contribute to th	e cause of d	
Ö	w requir been si should I	ete	coldmal					24a. Was	20	24b. Were auto	nav findings	availabla
al Re	: The lavicate has page 2:	Completed	COS PUI	morale.				auto	psy ormed?	prior to cor death? 1 ☐ Yes	npletion of c	ause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to me ical examiner?	Hospital:			Other	ath Check only				
o	Phys this ral di	To.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien	I 3L DOA	4 U Nursing i			Other (Specify	"	
	ding I	lo Lo	1 Natural 5 Pending	(Month, Day Year)	Injury		njury at Work? 1 □ Yes 2 □ No	28d. Describe	now injury	occurred		
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia				28f. Location (City or To	Street and wn, State)	Number or Rura	l Route Num	ıber,
	e Hospita 24 hours Funera letely fille	edical C	29a. Certifying Phy (Check only one)	/sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the	e time, date and place ny opinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as st place, and due to	ated. the cause(s	i)
	To th withir To th compl	Me	29b. Signature and title of certifier	11			ense number		29d. Date	signed (Month, I	Day, Year)	
			> Hayle	daz 1	N	D	53691		/	May :	3. 20	06.
	8		30. Name and address of person who d	completed cause of death (Iter	п 23a) (Туре, Ре V	Print)	53691 y Bivd,	Bei	es de	, Mo	. 208	17,
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's Signa	ature A	ade						

DHMH 17 Rev 1/2001

WALKER, ILATHRYN S/2/06 1725PM

			State of Maryland / Depa	artment of Health and Mettificate of Death		2006	15913
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death	No O O O	3. Time of Death
	Physicia /Medic		MARGUERITE DARNER	WERKING	May May	4, 2006	11:55 P M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
				Frederick		Frederick	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 24,	ear) 9. Birthe Cour 1913 Mary	place (State or Foreign
	ס		Usual Residence of Decedent		Julie 24,	1915 Mary	Tanu
	anylan show	<u>_</u>	10a. State 10b. County 10c. City, Town or Loc	ation		1	Od. Inside City Limits
	Ne Mark	Director	Maryland Frederick Frederick 10e. Street and Number	Tray 7: 0.1			1 ☐ Yes 2 ☐ No
	with l		200 East 16th Street	10f. Zip Code 21701	10g	. Citizen of What Cour	ntry?
	ms 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	Vas Decedent of Hispanic Origin? (Spec	cify Yes or No-	14. Race - Americ	can Indian,
ဖွ	or Ite	Fur	1 Never Married 2 Married 1 Yes 2 No	'Yes, specify Cuban, Mexican, Puèrto R ☐ Yes ②☐ No Specify:	lican, etc.)	Black, White,	etc.
8	filed within 72 hours after death with the Maryland Hygiene. Hygiene staturel', or Items 23a or 28a-f show ent, Ire Medical Examination must be notified at	d by	31 Wildowed 4 □ Divorced Year or Dates:				ite
7	n 72 i	Completed	(Specify only highest grade completed) (Give life, D	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	g 16	b. Kind of Business/Ind	dustry
212	d with giene. r thar	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	:	Own Home	
힏	al Hyg	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name		iden Sumame)	
<u> </u>	2 should be filed within 72 hours after death with the Marylan and Menthed th Hydens is metked to ther than "naturel", or litems 23a or 28a-1 show aumatic event, it a Medical Examination must be notified as	70	Joseph William Darner	Alice Eliz			
Maryland 21215-0036	s 1 and 2 should Health and Men Item 27 Is marke othar traumatic			g Address <i>(Street and Number or Rural</i> Ler Lane, Middletov			Code)
<u>a</u>	of Health of Health litem 27		20a. Method of Disposition 20b. Place of Dispos			c. Location - City or To	own, State
Itimore,	Pages nent of ant: If it ary or o		1 \ Burial 2 \ Cremation 3 \ Removal from State \ \ \ 4 \ Donation 5 \ Other (Specify) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		5 Fre	ederick, Ma	aryland
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signatore of Funeral Service Licensee	Name and Address of Facility BERT E. DAILEY & S	SON, FUNE	RAL HOMES.	P.A.
	å □ <u>►</u> 6 0		10000 (100000 1)	01 ΝΟΡΤΗ ΜΑΡΚΕΤ ΟΊ	ות שמש יו	EDICK MD 3	21701
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final			'	Approximate Interval Between Quset and Death
	Pnysician /Medical		disease or condition resulting in death) Due to (or as a onsequence of):	2 head fail	4xe		× week
8	Examiner						
	₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	and I-trans	Examiner	Cause (Disease or injury that initiated events c				
8760,	cate be executed physician and the burial-transit	dical E	d d				
9	ifficate g phy: as the	edic	0.			1	
Š	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of delive	•
O. B	tt the dea by the at tached fo	Physician/Me		Other (specify)		Month	Day Year
<u>a.</u>	res that thighed by	Ph)	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
ecords,	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	d by		, ,	1 🗆 Yes	2 No 3 Prob	
Ö	s been si	Completed			24a. Was an	24b. Were autor	osy findings available
\simeq		Com			autopsy performed	death?	npletion of cause of
Vital	ifcien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (
	Physi this c	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of			e 6 Other (Specify)
on	ding h. After funer	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	3d. Describe how i	njury occurred	
Division of	Attendi er death. ector: A by the fu	iflca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre	et, factory, office 28	f. Location (Stree	t and Number or Rural	Route Number,
	tel or Att rs after d al Direct ed in by	Certificati	4 Homicide Getermined building, etc. (Specify)		City or Town, S	ta te)	
	Hosp 4 hou Funer fely fill	Medical	29a. Certifier Certifying Physician: To the best of my knowledge, death (Check only Medical Examiner: On the basis of examination and/or investigation)	occurred at the time, date and place, an estigation, in my opinion, death occurred	nd due to the cause I at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, E	Day, Year)
	- S - Ö		Shah Hiren	D \$57643		5/5/0	5
9	,		30. Name and address of person who completed cause of death (Item 23a) (Type, P	'rint)		1/01	
			31. Date filed (MonMay, YA) 2 2005 32. Pagistrar's Signature	Ses Pr F	redo	rick my	121702
	Sta Registr		31. Date filed (Month Pay: Y4)/18 2006 32. Soistrar's Signature	rede			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death g Month Year Physician Young Suzanne May 2, 2006 2:20 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Salisbury Wicomico 30217 Wildlife Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1 □ M 2 X F 085-24-8143 75 Director 4/14/1931 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23e or 28a-f show traumatic event, the Modical Exeminant mast be notified at 1 Yes 28 No Salisbury Director Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30217 Wildlife Lane 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill h and Mental H 7 Is marked oth Be Clinton E. Junk Maime Starkey ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an James L. Young/husband 30217 Wildlife Lane, Salisbury, MD 21804 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 XBunal 2 ☐ Cremation 3 ☐ Removal from State 5/23/06 Arlington, Va 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Leensee 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that except the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TATIL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, ettending physician the th as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year ō Month Day 4□Pregnant at time of death 5 Other (specify) ed by the e o 9 Unknown Division of Vital Records, P. signed b 23e. Did tobacco use contribute to the cause of death? Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 s autopsy performed? Yes 2 No certificate 1 TYes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 - Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 200 2 1 🗌 Yes funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending investigation hours after death. Ineral Director: Aft y filled in by the fur 2 Accident 1 Tyes 2 | No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours after To the Funeral Dire Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NA6 278 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 1733 MO 21802-Coust! costal 31. Date filed (Month, Day, Year) 32. A gistrar's Signature 05 2006 Registrar

ORIGINAL

			1 - For State of Mai		artment of Health and Martificate of Death	· ·	ne No.2016	15915	
			Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death	
	Physici /Medio		Robert W. Ashle	У		May 19,	2006 Year	1:00 PM M	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	1	
			2911 Andorra Ct.		Baltimore		Baltimo		
	Funeral Director		218-18-2917 ^{1Д M 2□ F}	(In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 24, 1	9. Birth Cou 1924 Mary	place (State or Foreign Intry) Land	
	and *		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ecation			10d. Inside City Limits	
	Aaryli Peho	ō						1 ☐ Yes 2 ☐ No	
	the 1	rect	MD Baltimore	<u>Baltimore</u>	10f. Zip Code	100	Citizen of What Cou	X	
	3a or	Funeral Director	2911 Andorra Court		21234		U.S.A.	,	
	deat	ner	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13.1	Was Decedent of Hispanic Origin? (Sp. f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri		
9	or its	/Fu	1 Never Married 2 Married 1 ☐ Yes 2 No)	1 ☐ Yes 2 🕅 No Specify:	rican, etc.)	Black, White		
5-0036	within 72 hours after death with the Maryland ene. then *naturel', or iteme 23a or 28a-f ehow the Madical Examiner is ust be motified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give X Year or Dates:				Specify: Wh	1 te	
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212	withi ene.	шс	Elementary/Secondary (0-12) College (1-4or 5+)	.)	nolsterer		Upholster	v	
D	be filed within 72 hours after death with the Marylar Ital Hygiene. Id Hygiene. In other then "naturel", or iteme 23a or 28a-f ehow event, the Medical Examiner must be multiped at	Be C	17. Father's Name (First, Middle, Last)			(First, Middle, Maid	_ •	J	
Maryland		To B	Albert Ashley		Helen	Biggs			
Ma	C1 (0 == 0		19a. Informant's Name/Relationship (Type, Print) Marie Wickert- Sister		ng Address <i>(Street and N</i> um <i>ber or Rure</i> Burridge Road Bal				
	1 and Heelth em 27 Ither to		20a. Method of Disposition	20b. Place of Dispo			Location - City or T		
و	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	natory or other place) Memorial Park 5/2		ltimore,		
Baltimore,			4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Heather	1	. Name and Address of Facility		•	•	
ñ	permit. Departe Importe any inj		I Ceally (du	0.83	5305 Harford Road		CONTRACTOR CONTRACTOR		
			23a. Part1. Enter the disease, or complications that caused the shock, or heert failure. List only one cause on each line	he death. Do not ent	er the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition ATTEROX	cuforic	CAPBIOVASCACAR	DISANS		Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a	consequence of):	CAPDIOVASC 4CAR		t to	G Re T	
	LXdiffile	_	Sequentially list conditions.		RESURE		1	10 PEARS	
	ted nsit	Examiner	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause (Disease or injury	consequence of):					
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õ	4 5 5	ledi							
X Q Q	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the cost 12 months? 23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy		23d. Date of delive	,	
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ecords,	w requires that the been signed by th should be detache	ed by	VALVACAR HEART DISPUSE	-	idenying cause given in Fact.	1 Yes	10	pably 4 Unknown	
ပ္တ	≥ 0 0	plet	ATFIRE FIBRILLATION			24a. Was an	24b. Were auto	opsy findings available	
	ucian: The lar certificete has rector, page 2	Completed				autopsy performed	prior to co death? No 1 ☐ Yes	mpletion of cause of 2 No	
VIII II	stcian: certific irector,	Bec	25. Was case referred to medical examiner?		26. Place of Death		140 1.03	20110	
5	Physik this co	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient		t 3 DOA Other: 4 Nursing Hor	ne KResidence	6 ☐Other (Specif	'y)	
<u></u>	De Ter	ë.	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury	Work?	28d. Describe how in	ijury occurred		
UNISION	uttendly death. ctor: Aly y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be 389 Bloom of Injury	y - At home, farm, stre	M 1 Yes 2 No	204 Lanatina (Caran	(N)		
2	efter of Direct of in by	Certification;	4 Homicide determined 256. Place of mjury building, etc.	(Specify)	eet, ractory, office	City or Town, St	and Number or Rura ate)	al Houte Number,	
	To the Hospital or Attenwithin 24 hours effer deati To the Funeral Director: completely filled in by the		29a. Certifier (Check only cont.) 1 Certifying Physician: To the best of a cont. 2 Medical Examiner: On the basis of e	my knowledge, death	occurred at the time, date and place, a	and due to the cause	e(s) and manner as s	tated.	
	To the within 2 To the complet	Medical	and mapper state	HG.					
	EZES		Mall ()/H di))	7 21/89	290.1	Date signed (Month,	2006	
	1		30. Name and address of person who completed cause of dea	oth (Itam 22a) (Tue-	Print)	7	11/1/1/2		
,	3		Michael T. Minimon Soft, Minimorphisted cause of dea	88/3 WAL	THE WOODS RD.	BAGINORF.	10 2/2	34	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	29c. License number D3//89 Print) THAM WOODS RD, A	-, -,		/	
	Registr	ar	MAY 2 2 2006	w st. A					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 18 2004 William Joseph Addicks, Sr. 05 0137 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regionse NICOMICO SAUISBUR PONIN 34CA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1₺ M 2□ F 216-20-4284 78 Director July 31, Maryland Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23s or 28s-f show injury or other treumatic event, the Medical Examiner must be notified at 1 ∏Yes 2 X No Director Delaware Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37237 Sand Dollar Lane 19975 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 No 2 No 1946
If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Maryland 21215-0036 1 Yes 2 No Specify: White Specify δ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Lithography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Addicks Margaret Vandeveer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 te
eny injury or other treu 37237 Sand Dollar Lane; Selbyville, DE Date Date 20c. Location - Cit Helen Addicks Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/22/2006 Lorraine Park Woodlawn, Maryland 21. Signature 1 Furthal Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA WEEKS /Medical Due to (or as a consequence of): **Examiner** FAILURE RENAZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner l or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit INFA RCTION MYOCARDIAL Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification; 1 Natural 5 Pending Injury 1 Yes 2 No I Director: And in by the f investigation death. 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and close, and due to the course(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ercor Ph.O. M.D. D58689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Swier Kosz 100 E. Carroll St. 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature, State MAY 2 2 2006 Sallage s Registrar

Box 68760.

Please Type or Print in Black Indelible Ink

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State of Maryland / Department of Health and Mental Hygie	en

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Physicia		Regist.ar 1. Decedent's Name (First, Middle,La	st)		-		2. Date of Death	E 0 C	3. Time of Death
Medical Exami		Kimberlv	Ther	esa	Adam		Month I May 12, 200	Day Year D6	1834 hrs
¥		4a. Facility Name (if not institution, g	ve street and number)		4b. City, Town, o Baltimore	r Location of Death	n	4c. County of Dea	th
		40 Upmanor Road 5. Social Security Number 6. \$	7 Age	(In yrs. last bir		ar If Under 24Hrs	s 8 Date of Righ	(MM/DD/YYYY) 9. B	irtholago (State or
Funeral Director					Months Day		1.	Fore	
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any		10a State 10b. County	1	0c. City, Town					10d Inside City Limits
Maryland 28a-f show a	ъ	MD NA		Balt	imore				1 X Yes 2 No
Maryl - 28a-1	rect	10e. Street and Number			10f. Zip Code		10g	Citizen of What Co	untry?
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ath wi	Funeral Director	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent E Armed Forces?		13. Was Decedent of H If Yes, specify Cuba			14. Race - Ame White, etc.	rican Indian, Black,
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ical E	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)			illed)	C-16 D	-1
OO3	E	12th grade 17. Father's Name (First, Middle, Las	lyr		Taxi Cab	<u>.</u>	e (First, Middle, Ma	Self Em	proked
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be						d Simmor	•	
213 ould b ould b d Men s mar lic eve	5	Frank Adamson 19a. Informant's Name/Relationship	Type, Print)	19	b. Mailing Address (Stre				e, Zıp Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene, ant: If item 27 is marked other than 'or other traumatic event, the <u>Medical</u>		Mildred Adamso	n-Mother	1	49 North Mof Disposition (Name of Co	<u>lonaster</u>	cy Ave I	Baltimor	e, Md 2122
ore, slar of Hea of Hea		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from Stat		of Disposition (Name of co tory or other place)	emetery,	Date	20c. Location - City o	r Iown, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specia		Garr	ison Fores	st Vet 5	5/22/06	Owings	Mills, Md
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	insee Q		22. Name and Address March F/H	l West	D . 1		01015
Physician	6	23a. P rt I. F ter the disease, or con	plication that caused the	he death. Do n	4300 Waba oot enter the mode of dying	asn Ave A g, such as cardiac	 Balting or respiratory arres 	nore, Ma t, shock, or heart	21215 Approximate Interval
/Medical		failure. List only one cause on Immediate Cause (Final disease	each line. a Complications of	torsion of	ovarian cyst				Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consec		, ,				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	allence of):					
	mine	cause. Enter Underlying Cause							
v ed √	Examiner	events resulting in death) Last	Due to (or as a consec	quence of):					
execur an and al - tra	ical	UNPENDED	AMENDED				·		
760, icate be executed physician and the burial - transit	Medical	IF FEMALE:	23c. If yes, outcome	e of pregnancy	,			23d. Date of delive	ry
687 certific ding p	'sician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at ti			Ectopic pregn	ancy	Month	Day Year
Box e death c the atten ed for us	ysic	1 Yes 2 No 9 V Unknow		ine or death	5 Other (Specify)				
	/ Phy	Part II. Other significant conditions	contributing to death	but not resultir	ng in the underlying cause	given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ries that the signed by	d by						1 Yes	2 ✔ No 3 Pro	bably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s neral director, page 2 should	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Reco	m _O						perform 1 Y Yes 2		es 2 No
tal F	Be C	25. Was case referred to medical examiner?	Hospital: Inpatier			ce of Death (Check			
F Vid Physic or this	Tol	1 ✓ Yes 2 No 27. Manner of Death	i inpution		Outpatient 3 DOA Time of Injury 28c. Inj	Other Nursi		esidence 6 🗸 Othe	er: Scene
n of Viding Ph; h After tl e funeral	ion:	1 Natural 5 Pending	28a. Date of Injur (Month, Day,Ye	ar) 200.	, ,	Yes 2 No	28d. Describe ho	w injury occurred	
Division rate of a Division as after death as Director: A led in by the fu	ertification:	2 Accident Investiga	28e Place of Init	ury - At home, f	farm, street, factory, office		28f Location (Str	eet and Number or R	ural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	ertif	3 Suicide 6 Could no determin	ot be				or Town, Sta		
Hosp 24 hov Fune stely fi	al C	20a Cortifica	cian: To the best of my	knowledge, de	eath occurred at the time, o	date and place, and	d due to the cause(s) and manner as sta	rted.
To the Hospital within 24 hours To the Funeral completely filled	Medical	2	er: On the basis of exam and manner stated.	ination and/or	investigation, in my opinio				
	Σ	29b Signature and title of certifier	- 000			nse number		29d Date signed (M	onth, Day, Year)
		Tallem	u-toll	la s		.M.E. 		May 13, 2006 	
2+1		30. Name and address of person wh Patricia Aronica-Pollak N			miner 111 Penn S	Street, Baltimo	re, MD 21201		
	tate					,			
Regis		31. Date filed (Month, Day, Year) MAY 2 0 2	006 Recen	, H	Society p				
DHMH 17 Rev 1/2	2001			OF	RIGINAL				

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 17 GOODRICH D. BRAME JR. MAY 2006 6:30A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4403 KATHLAND AVENUE BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min **X**XM 2□ F Yrs 237-18-1383 87 05/28/1918 N. Director Carolina Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f ehow Examiner must be notified at XXYes 2 □ No MD N/A BALTIMORE CITY Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4403 KATHLAND AVENUE 21207 USA death 12. Was Decedent Ever in U.S Armed Forces? US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: BLACK ð 3X Widowed 4 □ Divorced *naturel*, Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) during most of working DEPARTMENT OF Elementary/Secondary (0-12) College (1-4or 5+) CIVILIAN PERSONNEL 12TH THE ARMY YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, and Mental h Pages 1 and 2 should be GOODRICH D. BRAME SR. BETTIE THOMAS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GOODRICH H. BRAME / SON 2702 N. LONGWOOD ST., BALTIMORE, MD 21216 item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō <u>∓</u> 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department o Important: If eny injury or once. 5/22/06 METRO CREMATORY CATONSVILLE, MD 21. Signature 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Imm Cause (Final Previoria **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any leading to him eclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown δ Division of Vital Records, P. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? certificete 1 ☐ Yes 2 K No 1 ☐ Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٩ this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Director or mpletely filled in by 4 | Homicide To the Hospital 1 Conflying Physician: To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - MO PhD DH8261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FI Rd # 25 Lutherville MD 21093 10753 Il cord L y Mo Phy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2006 Registrar

		1	1 - For State Registrar	State of Marylan				lealth a Death	nd Me		jiene g	006	5919
			1. Decedent's Name (First, Middle, Las	st)				-		2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Norbert Ger	ard Bond						MAY	20	2006	21:15 PM
	Examin		4a. Facility Name (If not institution, give	street and number)	and number) 4b. City, Town, or Location of De			f Death		4c. Co	unty of Death		
			SAINT AGNES MI	SPITAL			HLTIM						
	Funeral		5. Social Security Number 6. S	ON M 2DE	1	If Unde Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day	Year)	9. Birth Cou	place (State or Foreign ntry)
	Director		217-20-1037	79	Yrs.					July 2	, 192	6 Mar	yland
	and and		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Lo	cation						T	10d. Inside City Limits
	Aaryl f eho	ច	Maryland Baltimo	TO Cot	onsvil	1.							. 1 ☐ Yes 2 ➡ No
	the the	Director	10e. Street and Number	ie cat	OHSVII		p Code			1	Og. Citizer	of What Cou	ntry?
	3a or		2302 Edmondson A	venue			2122	28			TT	SA	
	me 2:	Funeral	11, Marital Status	12. Was Decedent Ever in U.	.S. 13. \	Nas Deci			in? (Spec	ify Yes or No- ican, etc.)		Race - Ameri	
CO.	ther the	교	1 Never Married 2 Married	Armed Forces?	1				, Puerto H	ican, etc.)		Black, White,	
ğ	al', o	b	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I □ Yes	2 12 1 No	Specity:			Sp	ecify:	White
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7	ygier ygier tt.	Ö	8		Mech	anic		40 14-41	A- Al	(First, Middle,		omotive	2
בַ	be fi	Be	17. Father's Name (First, Middle, Last) Arthur Norman B									,	
<u>₹</u>	Mer Mark Mark	P			401 14 17		(0)			rtrude			0.11
ă V	12 sh n and n ion	7.4	19a. Informant's Name/Relationship (19a Martin C. Bond	Son		•				Route Number Phoenix			•
е,	1 and fealth		20a. Method of Disposition		lace of Dispo			T	Da Da			ion - City or T	
Baltimore, Maryland 21215-0036	in its		1 🕮 Burial 2 🗆 Cremation 3 🗆	Removal from State	emetery, cren rison	natory or	other plac		30/2				
Ē	t. Partmer		4 Donation 5 Other (Specify					, -					, Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show empty injury or other traumatic event, the Madical Examinat must be notified at ODGs.		21. Signature of Funeral Service Licen	THS_	1	Fun	eral Edmor	Home	of C	atonsvi ue; Cat	11e,	Inc.	Witzke ID 21228
			23a. Part1. Enter the disease, o com shock, or heart failure. L'it only	plications that caused the deat	h. Do not ent	er the mo	de of dyin	g, such as c	cardiac or	respiratory arr	est,	LLLE, P	Approximate Interval Between
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	/Medical		disease or condition resulting in death)	Due to (or as a conseq								-	
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		ē	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq								-	
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8760,	The law requires that the death certificate be executed sie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical		d. RENAL FAI	LURE								
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Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta	Ideath 3□	Ectopic	oregnancy				230	. Date of deliv Month	ery Day Year
P.0.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	eath 5) Other (s	рөспу)						
	that the sed by detac	4	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlyina	cause dive	en in Part I.		23e. Did to	bacco use	contribute to I	the cause of death?
ds,	sign d be	d by			-					1 3 . Y	es 2 🗆 N	io 3∐Proi	bably 4 DUnknown
ŏ	w requir been si should	Completed		-						24- 146		dh Masa aut	findings available
3e	hes hes	E I								24a. Was a autops perfor	sy	prior to co death?	opsy findings available empletion of cause of
<u>_</u>										1 ☐ Yes	2 💢 No	1 🗆 Yes	2 □ No
⋚	Physician: The I r this certificete he ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othe	0.0		Check only or			
Division of Vital Records,	Phy r this ral di	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatien		UA	4 Nur		e 5 🗆 Reside			<i>fy)</i>
on	ding th. Afte fune	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	28c. Injun Worl	k? Yes 2∐N					
S	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, str	eet, facto	ry, office		28	Bf. Location (S	treet and N	lumber or Run	al Route Number,
<u>S</u>	s after al Direct of in by	Certification:	4 Homicide	building, etc. (Specif	y)					City or Tow	n, State)		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurre vestigation	d at the tim n, in my op	ne, date and pinion, death	d place, ar h occurred	nd due to the c d at the time, d	ause(s) and ate and pla	d manner as s ace, and due t	stated. o the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier			25	c. License			2	9d. Date s	igned (Month,	Day, Year)
			· SC.	$M \cdot D$			P 20	1347			MAY	20 20	06
	11.		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type,	Print)	-						
	077		RAHUL JAIN	Cat.	VENUE	BA	LTIMO	RE M	D 21	229			
	Sta Regist		31. Date filed (Month, Day, Zear)	32. Registrar's Signa	ature								

BOND, NORBERT

06-03385 Anthony Byrd Please Type or Print in Black Indelible Ink

inthony Byra		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Reg. No.
Physiciai Medical Examin		1. Detedent's Name (First, Middle Last) Annony Annony Byrd 2. Date of Death Month Day Wear May 19, 2006 3. Time of Death 0334 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Saint Agnes Hospital 4c. County of Death Baltimore
[*] Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 16. Sex 7. Age (In yrs. last birthday) 16. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Date of Birth (MM/DD/YYYY) 19. Birthplace (State or Months) 19. Days Hours Min. 19. 15. P. 75 19. Country) 19. Country) 19. Country) 19. Country) 19. Days Hours Min. 19. 19. 19. 19. 19. 19. 19. 19. 19. 19.
any	È	Usual Residence of Decedent 10a. State
ž .	ا <u>ة</u>	MD Baltimore Essex 1 Yes 2 X No 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country?
with the Maryland ms 23a or 28a-f sho be neiffed at once.	Director	10e. Street and Number 1022 Commodore Drive 21221 10g. Citizen of What Country? USA
r death	/ Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
5-0036 lied within 72 hours after Hygiens "natural", Jother than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Comp	17 Father's Name (First, Middle, Last) Ayrs Volice Officer Baltimore City 18 Mother's Name (First, Middle, Maiden Surname)
	To Be	Antkony Byrd 19a. Informant's Namer elations up (Type, Print) 19b. Mailing Address (Street and Number, or Rural Route Number, City Town, State, Zip Code)
MD and 2 sho salth and 2 sho salth and sm 27 is raumati	-[Laquitus. Byrd / Wite 122 Commodore Dr. Essex, mb 2 221 202 Mathod of Disposition 204 Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State
ે જું કે <u>કે</u>		1 Burial 2 Cremation 3 Removal from State Crematory or other place 4 Donation 5 Other Specify: Duraney Valley 5/22 06 Timonium KD
Baltimo permit. Page Department Important: injury or ott		21. Signature of fun rai Service Licentee 22. What a proposition reene funeral Services 8728 Liberty Rd. Randallstown, MD 21133
Physician /Medical		23a. Part I. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a Head Injuries and Compressional asphyxia Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated
nd rransit		events resulting in death) Last Due to (or as a consequence of): d.
760, cate be executed physician and he burial - transit	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
lox 687 leath certifu e attending for use as t	Physician/N	23b. Was decedent pregnant in the past 12 months? 1
P.O. Es that the d	ব	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the safter death of the This certificate has been signed by led in by the funeral director, page 2 should be detacled in by the funeral director, page 2 should be detacled.	Completed	24a. Was an autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The his certificate director, page	Be Co	1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one)
of Vit. Physici er this c	리	examiner? 1 V Yes 2 No 27. Manner of Death A Dot Dother 1 Death A Dother 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ision of Attending Ph or death rector: After i	ation	1 Natural 5 Pending Nay 19, 2006 O242 hrs 1 Yes 2 No Driver auto auto collision
Division ospital or Attenchours after death hours after death uneral Director: y filled in by the	Certification:	Suicide Homicide Suicide Homicide Suicide Homicide Could not be determined Could not be determined Specify) Local Street Stafford Street & Parksley Ave, Baltimore, MD
D To the Hospital within 24 hours To the Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To viii	Me	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 19, 2006
00		30. Name and a dress of person who completed cause of death (Item 23a)
Sta	ate	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature
Regist	_	31. Date filed (Month, Day, Year) MAY 2 2 2006 32 Registrar's Signature

06-03277 Joseph Barton

Please Type or Print in Black Indelible Ink

sepn Barton		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. N	2006 1592
Physician	1	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day	3. Time of Death
ledical Examine	•	O OG DIT IT DOLL TO THE OFFI	4c. County of Death
es market		Northwest Hospital Center Randallstown	Baltimore County M/DD/YYYY) 9. Birthplace (State or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (Months Days Hours Min. 11-2-19 Usual Residence of Decedent	Foreign -
nd show any		10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City Town or Locat	10d Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show tifted at once.	2	10e. Street and Number 10f. Zip Code 21117	Citizen of What Country?
JD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f stumatic event, the Medical Examiner must be notified at one		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
nours after atural", xaminer	eted by r	3 Widowed 4 Divorced if Yes, Give Year 1 Yes 2 No specify:	b. Kind of Business/Industry
5-0036 He within 72 Hygiene tother than "r	립	thet It	Food Services
e, MD 21215-0036 I and 2 should be filed within 72 hours after death will Health and Mental Hygiene item 27 is marked other than "natural", or items r reaumarie event, the Medical Examiner must be	8 	Woseph A. Barton, Or. Arlene Ke	vels
- p # # # #		Dosephine Barton/Sister 19715 Branch leigh Rd, Kar	dallstown, ND 21(33) Dc. Location - City or Town, State
MOF Pages nent of ant: 14	i	1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Deponation 5 Other Specify: 21. A gnature of Funeral Service Licenses	Baltimore, MD
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	own MP 2/133 shock, or heart Approximate Interval
Physician /Medical Examiner	ł	failure. List only one cause on each line. Immediate Cause (Final disease a. Heroin intoxication	Between Onset and Death
		Sequentially list conditions,	
		cause. Enter Underlying Cause	
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k 687 n certific ending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	23d. Date of delivery Month Day Year
O. Boy tt the deatl I by the att	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact	cco use contribute to the cause of death?
res that signed b	ক্র	1 Yes 2	2 No 3 Probably 4 V Unknown
ords, F w requires is been sig	Completed	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
tal Recol	ۊ	performed 1 V Yes 2	d? death? No 1 ✓ Yes 2 No
/ital ysician: his certifi director,	a	25. Was case reterred to medical examiner?	sidence 6 Other.
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the state death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	<u>ان</u>		injury occurred
Sior Attend r death. ector: by the	catic	Natural 2 Accident Signature Find 5/15/2006 Find 5:40 pm 1 Yes 2 X No unk Notice Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street)	et and Number or Rural Route Number, City
Division of Nospital or Attending Ph. hours after death.	Certification:	3 Suicide 6 X Could not be determined (Specify) house Delight, N	et and Number or Rural Route Number, City 241 Pittston Circle
To the Hospita within 24 hours To the Funeral completely fille	Medical (I place, and due to the cause(s)
	Ž		9d Date signed <i>(Month, Day,</i> Year) //ay 16, 2006
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	ate	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regist	rar	ar NAY 2 2 2006 See 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAY 11:25P M RAHIM BANIHASHEMI 15, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/25/1944 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min XIXM 2 F 62 Yrs. IRAN 217-50-2770 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits itams 23a or 28a-f show th and Mental Hygiene. ?7 is marked other than "natural", or itams 23s or 28s-f show traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director BALTIMORE PERRY HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA Funerai 26 PERRY WOODS COURT filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: IRANIAN δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) R K& K College (1-4or 5+) Elementary/Secondary (0-12) HIGHWAY CONSTRUCTION CIVIL ENGINEER 4+ YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 is marked off Be SEYED HOSSEIN BANIHASHEMI GHAMAR SADAT MIRMIRAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL BANIHASHEMI/SON PERRY HALL, MD 26 PERRY WOODS COURT 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: If sny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 5/20/2006 BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CORONARY ARTERY DISEASE /Médical Due to (or as a consequence of): Examiner CARDIAC ARREST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that include aspects) Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed CHRONIC RENAL EATLURE that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending within 24 hours after death.
To the Funerel Director: Al 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospitel Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sista D 00063976 30. Name and address of person who comp and cause of death (Item 23a) (Type, Print) IMBAN SIDDIDI M. D. 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE TOWSON MARYLAND 21204 32. Registrar's Signature State Registrar flow to fresh

ORIGINAL

06-03167 Please Type or Print in Black Indelible Ink Janice Baker State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Renistrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1610 hrs Medical Examiner May 10, 2006 Janice Baker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2502 Eutaw Place 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State of **Funeral** Min Months Days Hours unk Director 1 M 2 X F Country) NY 128-30-3624 66 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show MD , or items 23a or 28a-f shor must be notified at once. Baltimore more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? unk ō U.S.A. 2502 Eutaw Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. unk 1 Never Married 2 2 X No Yes Yes 2 X No specify: 3 X Widowed If Yes, Give Year Divorced Specify: traumatic event, the Medical Examiner black marked other than "natural" þ or Date 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4 or 5+) 12th Grade N/A Clerk Social Security Admin. unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be Eugene Boykin Pearl Hunter 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
207 N. Luzerne Avenue Baltimore, MD 21224 19a. Informant's Name/Relationship (Type, Print) item 27 i O.C.M.E. CHristopher Boykin 111 Penn Street Baltimore; MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Burial 2 X Cremation 3 permit. Pages l Department of H Important: If it crematory or other place) Removal from State Metro Crematory 5/27/2006 Baltimore, MD Donation 5 XO 21. Signature of Funeral Savice Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue State Anatomy Baltimore Street timore Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** hist only one cause on each line. Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X AMENDED item#5,9,10g,11,12,15,16a-b,17,18,19a-b,20a-c,22,perFH,G855,\$/31/06 TT UNPENDED the attending physician ed for use as the burial 23c. If yes, outcome of pregnancy IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. has been signed by è 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' certificate Yes 2 No Yes No 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medical the funeral director Be examiner? Other₄ After this Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 V Yes 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural 1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director:
completely filled in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 11, 2006 eted cause of death (Item 23a) 30. Name and address of person who comp 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5.19a-b.perInf. 0855.5/30/06 TT

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39.	100 6 001		Registrar 1. Decedent's Name (First, Middle, La	ist)		tinoato or i	Journ	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia	an	Gail		tas			Month May	18, 2006	1
	/Medic	S. 18	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea		4c. County of De	·
	Examin	er	14504 Georgia Av			Rock	ville		Montgom	erv
	Funeral		9	Sex 7. Age (In yrs. i	last birthday)	If Under 1 Year	If Under 24 Hrs			irthplace (State or Foreign
	Director		188-30- 2013	¹ □M 2√2F 69	Yrs.	Months Days	Hours Min	April 26	, 1937 Pen	nsylvania
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	how	<u>.</u>	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
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	a or 2	ā	10e. Street and Number			10f. Zip Code			10g. Citizen of What (
-	• 23	Funerai	14504 Georgia A	Venue 12. Was Decedent Ever in U.	C 121	20853 Was Decedent of H	innania Origina /		nited Stat	es nerican Indian,
	Item Item	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 ☑ No	.3.	f Yes, specify Cuba	in, Mexican, Puei	to Rican, etc.)	Black, W	
3	al', or	by F	3 ☐ Widowed 4 ♣ Divorced	If Yes, Give Year or Dates:		1☐ Yes 21© No	Specify:		Specify:	White
5	atura ical	ted	15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busines	s/Industry
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4	or th	Completed	12		Воо	kkeeper			Accounti	ng
3	d oth	Be	17. Father's Name (First, Middle, Last	0			18. Mother's Na	me (First, Middle,	Maiden Sumame)	
7	Men Men Marke	10	John F. Mulle				Mildr		nboth	
5	2 sh and 1 m		19a Informant's Name/Relationship Marie Maria Richarz/Dau	Type, Print)					r, City or Town, State	
<u>.</u>	1 and 4ealth 9m 27 ther t		20a. Method of Disposition					Date Date	k, CA 9105	
5	iges nt of h if ite		1 ☐ Burial 2 【Cremation 3 [THOMOVAL HOM State		sition (Name of natory or other place		100		
	it. Pa rtmer rtant njury		4 ☐Donation 5 ☐Other (Speci 21. Signature of Funeral Service Lice	**	_	y Cremato	1		Bethesda,	Maryland uneral Home
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. I important: If them 27 is marked other then "natural", or frems 23s or 28s-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.			Were M00092	Be Be	thesda-Ch	nevy Cha Maryland	se Inc 20814-3	7557 Wisc	onsin Avenue
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	iplications that caused the death			-			Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition	Chronic Obs	tructi	ve Lung D	isease			Onset and Death 15 years
	/Medical		resulting in death)	Due to (or as a consequ						-
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<	leath certifica attending ph I for use as th	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of d	elivery
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6	ures that the dei signed by the a id be detached f	by P	Part II. Other significant conditions	contributing to death but not resi	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
3	w require been sig should b							1 ½ Y	es 2□No 3□F	Probably 4 □Unknown
מ	as be 2 sho	plet						24a. Was a		autopsy findings available o completion of cause of
	The ete ha	Completed						perfor	med? death?	
	ertific ctor,	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only or		
-	hysic his ce I dire	10	1 ☐ Yes 2. ☐ No	Hospital: 1 Inpatient 2			4 Nuising i	Home 5√2 Resid	ence 6 Other (Sp	ecify)
S	ing P	on:	27. Manner of Death 1X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		28d. Describe h	ow injury occurred	
2	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not to	ne -			Yes 2 □No			
5	or At after of Direct in by	ertification:	4 Homicide determined		ome, farm, stri V)	eet, factory, office		City or Tow	itreet and Number or I n, State)	Rural Route Number,
	spital ours neral filled	O	29a. Certifier 18 Certifying P	hysician: To the best of my kno	wledge, death	occurred at the tim	ne, date and place	e, and due to the o	ause(s) and manner	as stated
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the long physician by the funeral director, page 2.	edical	(Check only 2 Medical Exe	miner: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my of	pinion, death occ	urred at the time, o	date and place, and du	ue to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier			29c. License			29d. Date signed (Mor	* * * * * * * * * * * * * * * * * * * *
			· Cee	Solle		03	3344	3	May 19.	2006
	10		30. Name and address of person who Alan Pollack, M.D			r naty			*	
	Sta			32. Registrar's Signa			, MOCAV.	LLLG, FIGI	утани 200.	<i>)</i>
	Registr	ar	WIAT & & ZUUI	properties for	Sal Sales					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . ^{Day}2006 May 18, Da Physician 12:30 a M Bower, Sr. Robert Bruce /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 2, 1928 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours 1**X**□M 2□F Maryland 215-22-4268 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Madical Exame as must be notified at Lutherville Baltimore 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 21093 1606 Pickett Road U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal once. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) I.B.M. Field Engineer Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be S. Elvira Valdivia Samuel Bower 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1606 Pickett Rd., Lutherville, MD 21093 Virginia S. Bower-wife Baltimore. 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hillton Srv Corp 5/19/06 Towson, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician **Physici** funcreatic (ancer months /Medical be to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 1 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural nours after death.
neral Director: Af 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D58303 MAY 13 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. CHARLES STREET TOWSON MD 21204 AMRON CHARLES IN 32. Rigistrar's Signature 31. Date filed (Month, Day, Year) State Call 143. Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	Disconici		1. Decedent's Name (First, Mid	dle, Lest,)							2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		Marguerite B	utz									28, 200		10:45 AM
	Examir		4a. Facility Name (If not institut	on, give	street and num	ber)					4b. City, Town, or L			y of Death	
			8800 Walther	B1vd	. Apt.	1513					Baltimore				
Т	Funeral		5. Social Security Number	6. Sex	x	. Age (In yrs.	last birti	nday)	If Under 1	Year	If Under 24 Hrs.	8. Date of B	irth	9. Birthp	place (State or Foreign
	Director		216-01-2625 Usual Residence of Decedent	1]M 2⊠F	89	١	rs.	Months	Days	Hours Min.	Nov 26		TN	ntry)
	and and		10a. State 10b. Coun	ty		10c. Ci	ty, Town	or Loca	ition					1	0d. Inside City Limits
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12-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show early injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Ma 3 🕅 Widowed 4 ☐ Divorce	rried	Armed Fore 1 Yes 2 If Yes, Give Yeer or Da	es? ∑∑No					lispanic Origin? (Sp an, Mexican, Puerto Specity:	Rican, etc.)	Speci.	ick, White, fy:	etc.
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yland	ald be fenta ked ic e	10 B	Stuart Leonar	d Co	x						Victoria	Isabe?	l Davis		
_	should be fand Mental I s marked of		19a. Informant's Name/Relation				19b.	Mailing	Address (Street	and Number or Rur	al Route Numi	ber, City or Town	, State, Zip	Code)
<u>8</u>	alth a 27 is r tra		Ester McNeill	/sig	ster		882	0 W:	althe	r F	31vd Balt:	imore.	MD 2123	<u>'</u>	
ā,	s 1 a f Hei f Hei item othe	Ì	20a. Method of Disposition				Place of	Disposit	ion (Name tory or oth	of		Date	20c. Location		wn, State
	Page ent c nt: If ry or		1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other (emoval from S	tate	,,	, 0,0,,,	,	o, pia	1				
Dallimo	permit. Departmimporta eny Inju		21. Signature of Funeral Service Ronald	S.	wade,	ixecto	ъ.	St	ate A	nat	ss of Facility	d 655 W	. Balti	more	Street
		_	23a Part 1 Exter the disease	or compli	pations that ca	read the dool	h Don	1			, MĎ 2120				Annundmate
	Disconining		23a. Part1. Enter the disease, shock, or yeart failure. Lis	st only on	ie ceuse on ea										Approximate Interval Between Onset and Death
A	Physician /Medical		Immediate Ceuse (Final		,	TSOL	1.00			10	art D	1 Sea	se.	1	
	Examiner		disease or condition resulting in death)	а						10		17 -01			
		ē				Due to (d	or as a co	onseque	ince ot):					i	
	uted d ensit	盲	Conversion, list on divine	6 b)	Due to (c	or ac o co	ntegue	nce of:			-		1	
·	rificete be executed ng physician and es the burial-trensit	fedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			D 40 10 (C	n as 6 00	niseque	noe on.					1	
5	ysicia ne bu	Cai	that initiated events	c		Due to (o	ras e co	пѕедие	nce of:				1		79.
8	ig ph es th	g g	resulting in deeth) Last Due to (or as e consequence of):												
5	andir use			d	l										
	death e att	Physician/	Pert II. Other significent condit	ions con	tributing to dea	th but not res	ultina in 1	he unde	erlvina cau	se giv	en in Part I.	23b. Did	tobecco use co	oribute to	the cause of death?
	t the by th tache	چ	Hur	PA-	Kusi	00			, ,				Yes 2000		ably 4 □ Unknown
, 0	gned be de	by	110/10	CY	Pusi	UVI							<u> </u>		
3	quire en siç ould b											24a. Was	an autopsy ormed?	24b. We	re autopsy findings ilable prior to
ָ כ	s ber	Set	AH 8-1									pen	omied?	соп	pletion of cause leath?
Ě	The la	Completed										10	Yes 2 TLNO	10	lYes 2□ No
<u> </u>	en: 1 tiffica tor, p	BeC	25. Was case referred to medic	al							26. Place of Deeth				
>	/sicf	일	examiner? 1 ☐ Yes 2 ☐ No	Н	ospital: 1 □ Inc	atient 2	ER/Outr	atient	3□ DOA	Oth			dence 6 □Oth	er (Specify	1
5	g Ph er thi		27. Manner of Death		28a. Date of (Month,		28b. Tir	ne of		. Injun			how injury occur		,
5	ath. Afte	읉	1 D Natural 5 □ Pend 2 □ Accident inves	ng igation	(Month,	Dey Year)	inj	ury	М		Yes 2□No				
2	Atter r dea ector by th	20 €	3 ☐ Suicide 6 ☐ Could	not be	28e. Place o	Injury - At ho	me, farn	n, street	, factory, o	ffice		28f. Location (Street and Numb	er or Rural	Route Number,
5	s effe	Certification:	4 Hollinoide		building	, etc. (Specif	V)					City or To	wn, State)		
	To the Hospital or Attending Physicien: The law requires that the death certificete be executed within £4 hours elater death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physi I Examin	icien: To the beer: On the bas and manne	is of examine	wledge, o tion end/	death oc or inves	curred at tigation, in	the tim	ne, date end place, a pinion, death occurr	and due to the ed at the time,	cause(s) and ma date end place,	nner as sta and due to	ated. the cause(s)
	with with	Σ	29b. Signature and title of certifi	ər 🕡	Λ.	2			29c. L	icense	number		29d. Date signe	d (Month, D	Pay, Yeer)
			Th	\nearrow	(1	V			1) :	17601		5	116	06
•			30. Name and address of persor	who cor	mpleted eause	of death (Item	23a) (T	ype, Prir	nt)	21	11 0	14.7	110 1	11	212211
			Galama	99	28	JU V	UGI	UV	للنر	PI	va, la	NEVI	ve, t	N	4004
	Sta		31. Date filed (Month, Day, Year		ESY .	istrar's Signa	ture	0.334	-		,				
	Registra		MAY 2 2	2006	THE .	50 Sept	ED ST	Section 1884	,						
LIE	4H 16 Day 6/05				-										

Registrar DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #16a Per FH G855 6 20 10 10 10 11 Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MAX 2006 Brown Sr. Arnold 5 Richard /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore St. Agnes Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□F Director 58 30 MD 212-46-1263 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified ut Yes 2□No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21207 Funeral 3611 Ferndale death Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Probation Officer 12th grade 4vrs+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Beatrice Heath William Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health as
important: if item 27 is, 3611 Ferndale Ave, Baltimore, Md Sharon Haskins Brown-Wife 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial ACremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc 5-20-2006 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West March 14300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 4 hours Cerebrovascular Accident Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ypertension Examiner Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Š signed to Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 KNo 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Ves 2 □ No 24a, Was an has autopsy performed? certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 nation 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No After this 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerat L 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife Torck 156226 11 clan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael 5. Ballo 900 cato Ave Baltimore 900 caton 32 Registrar's Signature State 0 2006 La Sereir Registrar

		For State Registrar	State of Maryland /	Certificate of	Death	Reg.	No.	1016
ysicia		Decedent's Name (First, Middle, Last)			2.	Date of Death Month	Day Year	3. Time of Death
Medic	al .	4a. Facility Name (If not institution, give s	John Joseph		r Location of Death	May	4c. County of Dea	th 10:00 A M
amin	er	Good Samarita	an Hospita		imore		NA	
eral ctor		220-36-108/	7. Age (In yrs. last)	birthday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreign ountry) aryland
ם	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
any injury or other traumatic event, the Medical Executar must be notified at once.	ctor	Maryland N/	'A	Ва	ltimore Ci	-y		1⊠Yes 2 No
pe Do	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	erai	5403 Knell Avenue	12. Was Decedent Ever in U.S.		21206		nited Sta	
	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔂 No	13. Was Decedent of H If Yes, specify Cuba		an, etc.)	Black, White	
	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	Sa. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of working d)	160	b. Kind of Business	/Industry
	Con		4 Years	Salespers			Hardware	2
	Be	17. Father's Name (First, Middle, Last)		all control of the state of the	18. Mother's Name (F			
	ဥ	William Albert 19a. Informant's Name/Relationship (Type)		9b. Mailing Address (Street		a Hinson oute Number, C		Zip Code)
ì		Mrs. Deirdre A. H	17.00	780 Irongate		kesvill		1784
		20a. Method of Disposition	20b. Place ceme	of Disposition (Name of tery, crematory or other place	Date	200	c. Location - City or	Town, State
		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	enioval Itom State	wood Cemetery	1	5	Baltimore	e, Maryland
once.		21. Signature Fineral Service License	E. Reel		ss of Facility Funeral Ho a Ave. Dun			Inc. 21222
dr.		23a. Part1. Enter the disease of compli- shock, or heart failure. List only or	cations that caused the death. D	o not enter the mode of dyin	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between
n		Immediate Cause (Final disease or condition	Respirator	y Failure	?			Onset and Death
al- er		resulting in death)	Due to (dr as a consequence	edof):	Soleros	ic (A	(15)	
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		OCIETUS	15 0		
	amlner	cause. Enter Underlying Cause (Disease or injury that initiated events						
28	E	resulting in death) Last	Due to (or as a consequence	e of):				
	cai							
	by Physician/Medical	IF FEMALE:	70. 16		-			
ı	ian	in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death				23d. Date of de Month	livery Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	3 Giller (spaciny)				
	y P	Part II. Dther significant conditions con	tributing to death but not resulting	g in the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
						1 🗌 Yes	2 12 No 3 □ P	robably 4 Dunknown
	0					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
	piete					performed	death?	2 🗆 No
	Complete					1 ☐ Yes 2 🖸	140 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	Be Completed	25. Was case referred to medical examiner?	leasibel.	014	26. Place of Death (C	1 ☐ Yes 2 ☑	10 10169	
	To Be	examiner? 1 ☐ Yes 2 ☑ No		Outpatient 3 DOA Oth	er: 4 🗆 Nursing Home	1 ☐ Yes 2 ☑ Check only one) 5 ☐ Residence	e 6 Other (Spe	cify)
	To Be	examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending	1 ≥ Inpatient 2 □ ERV	D. Time of linjury World	er: 4 🗆 Nursing Home	1 ☐ Yes 2 ☑ Theck only one)	e 6 Other (Spe	cify)
	To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home,	b. Time of Injury M 1	er: 4 Nursing Home y at 28c k? Yes 2 No	1 Yes 2 2 Residence Describe how i	e 6 Other (Speinjury occurred	
	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	b. Time of Injury M 1	er: 4 Nursing Home y at 28c k? Yes 2 No	1 Yes 2 ☑ Theck only one) 5 ☐ Residence Describe how i	e 6 Other (Speinjury occurred	
	Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) sician: To the best of my knowledner: On the basis of examination	o. Time of Injury Mor 1 Gram, street, factory, office	er: 4 Nursing Home y at k? Yes 2 No 28t 28t	1 Yes 2	e 6 Other (Spennjury occurred t and Number or Ritate)	ural Route Number,
ilipietely illed III by tile tariefat allectici, page 2 stoud og dataoried tot use as tile battar.	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Accident 3 Suicide 6 Could not be determined 29a. Certifier (Check only one)	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	o. Time of Injury Mori M 28c. Injury Mori M 1 farm, street, factory, office lige, death occurred at the time and/or investigation, in my or	er: 4 Nursing Home y at k? Yes 2 No 28t ne, date and place, and pinion, death occurred	1 Yes 2 Check only one) 5 Residence Describe how i Location (Stree City or Town, S) due to the causat the time, date	e 6 Other (Speinjury occurred t and Number or Ritate) e(s) and manner as and place, and dus	ural Route Number, s stated. b to the cause(s)
4	Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) sician: To the best of my knowledner: On the basis of examination	farm, street, factory, office lige, death occurred at the time and/or investigation, in my of	er: 4 Nursing Home y at k? Yes 2 No 28t ne, date and place, and pinion, death occurred	1 Yes 2 Deck only one) 5 Residence Describe how i Location (Stree City or Town, S) due to the causat the time, date	e 6 Other (Speinjury occurred t and Number or Ritate) e(s) and manner as and place, and due	ural Route Number, s stated. b to the cause(s)

State Registrar

DHMH 17 Rev 1/2001

MAY 2 2 2006

ORIGINAL

		-	1 - State of Maryland /	Department of H Certificate of	lealth and M <i>Death</i>		giene2 () (Reg. No.	06 15929
			Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
Е	Physicia		Robert James Comiskey			Month May 1	Day 19, 2006	6:45 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death		4c. County of	
н		4	Manor Care-Woodbridge Valley	Catons	sville		Balt	imore
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birthplace (State or Foreign Country)
	Director		074-20-0498	Yrs.		April 2	21,1927 N	Wew York
	pur &	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location				10d. Inside City Limits
	sho	5						1 ☐ Yes 2 No
	the N	Director	Maryland Baltimore Catons 10e. Street and Number	SVIIIe 10f. Zip Code			10g. Citizen of Wh	at Country?
	with 6 or	<u>a</u>	212 Brookside Drive		21228		USA	=1W_
	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of H	Hispanic Origin? (Spe	ecify Yes or No	- 14. Race	- American Indian,
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Its marked other then "naturel", or Items 23e or 28a-f show reumetic event, Ite Medical Examinat must be rightlind at	by Funeral	1 Never Married 2 Married Armed Forces? 1 Syes 2 No If Yes Give	If Yes, specify Cub	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc. White
Ö	hour:	d be	***	a. Decedent's Usual Occur	pation		16b. Kind of Busi	ness/Industry
<u>.</u>	in 72 "na" n	Completed	(Specify only highest grade completed)	(Give kind of work done life. DO NOT use retire	during most of worki	ing	700.1111001000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
7	with iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Cl	hemist Sales	Associate	2	Food &	Drug
D	i Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle,	Maiden Surname,)
Maryland 21215-0036	Juid be Jenta rked ric ev	To E	Arthur Comiskey		Helen Co	oy1e		
ary	and Name		1,7,7	9b. Mailing Address (Street				
Σ,	and 3			212 Brookside				
altimore,	of Hi		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	of Disposition (Name of tery, crematory or other pla	ce)	Date		ity or Town, State
Ē	Pag ment tent: jury o			son Forest	5/25/	2006	Owings M	Mills, MD hwab Witzke
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked eny injury or other treumetic esones.		21. Signature of Funeral Service Licensee	Funeral H	Home of Ca	(tonsvi	lle, Inc.	
	40300		23a. Part1. Enter the disease, or complications that caused the death. Do					e, MD 21228 Approximate
_		1	shock, or heart failure. List only one cause on each line.				11031,	Interval Between Onset and Death
	Physician /Medical		disease or condition a. H7FERTENST		ASCULAR	D15	EASE	
	Examiner		Due to (or as a consequence	e or):				
	100	er	Sequentially list conditions, if any leadin to immediate cause. Enter Underlying	e of):				
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
o,	e exection are are are are are are are are are are	Ex	resulting in death) Last Due to (or as a consequence	ee of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d					
9	entific ling p	Mec.	IF FEMALE: 23c. If yes, outcome of pregnancy				201 0.11	4 4-5
Вох	that the death certif ed by the attending detached for use at	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		у		23d. Date Mont	
P.O.	the de	ysic	1 Yes 2 No 9 Unknown	3 🗆 Other (apecity) _				
	that ted by	H.	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause giv	ven in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
Sp	uires signe	d by	TYPE II DIABETES	MELLITUS		10	Yes 2□No 3	Probably 4 Dunknown
COL	w requir been si should	Completed				24a. Was		ere autopsy findings available
Re	The lay ate has page 2	dmc					rmed? de	or to completion of cause of ath? ☑Yes 2☐ No
ta		a)	25. Was case referred to medical		26. Place of Deati	1 Yes		163 2010
>	Physician: r this certific ral director,	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatient 3 DOA Ott	ner: 4 Nursing Ho	me 5 Resid	dence 6 Other	(Specify)
Division of Vital Records,	ding Phys n. After this funeral di		1 Matural 5 ☐ Pending (Month, Day Year)	o. Time of 28c. Inju Wo	ry at rk?] Yes 2 □ No	28d. Describe I	how injury occurred	d
isi	l or Attending after death. Director: After In by the fune	lical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,			28f. Location (Street and Number	or Rural Route Number,
<u>≥</u>	el or A s after el Dire	Certification:	4 Homicide determined building, etc. (Specify)			City or To	wn, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.					
	withir To the comp	M	29b. Signature and title of certifier	29c. Licen:			29d. Date signed	(Month, Day, Year)
	1		by mo	Doo	59107		5/2016	•
10)		30. Name and address of person who completed cause of death (Item 23a		REIST	ERSTON	~ MD	21136
	Sta Regista		31. Date filed (Month Pary Year) 2006 Registrar's Signature	Aparts)				

			Please	ype or Print in Bia				•	
			For State	State of Maryland			Mental Hygie	neganc	15030
			1- State Registr Amend #5 Per	FH G856 6/15/06	Gertifica	te of Death	Reg.	No. L. UUO	10000
			1. Decedent's Name (First, Middle, Last	0 1	- 		2. Date of Death		3. Time of Death
	Physicia	an	(mrlio	Colem	00		Month _ C	Pay Year	2.15 AM
	/Medic		4a Ensility Name (If not institution aire			Town, or Location of Deat		4c. County of Death	S.IJA
	Examin	er	4a. Facility Name (If not institution, give	D . W	40.01	D - 11		4c. County of Death	
			930 N. Patte	USONTWILL	tue -	Daltimo	re		
	Funeral		5. Social Security Number 979 6. Se	x 7. Age (In yrs. last	Months	r 1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	olace (State or Foreign
	Director		220-03- 0470 "	81	Yrs.		2-/4	19 Sou	Harolina
	p ,		Usual Residence of Decedent	10- Ch. T					
	rylar thoy	_	10a. State 10b. County	10c. City, 1	own or Location				10d. Inside City Limits
	Ma -	5	MD	150	Itimo	ne e			1 res 2 No
	128 E	ě	10e. Street and Number		10f. Z	p Code	10g.	Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show I must be notified at	Funeral Director	930 N. Dettors	DAL DEN AL	, 0	21205		(15A	
	ns 2	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dece	dent of Hispanic Origin? (Socify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Ameri	can Indian,
	Ter ter	Ë	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XNo	If Yes, sp	cify Cuban, Mexican, Puer	o Rican, etc.)	Black, White,	etc.
2	hours after turel', or ite al Examine	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: R	ack
5	n 72 hours atter death with the Marylan "naturel", or items 23a or 28a-f show idical Examiner must be notified at	b	15. Decedent's Edu		6a. Decedent's Usi	al Occupation	161	o. Kind of Business/In	dustry
Ò	"na "na	e	(Specify only highest grad	e completed)	(Give kind of w life DO NOT	ork done during most of wo	rking	5. Talla of Basillos 3 il	dustry
V	within ene. then "	Completed	Elementar//Secondary (0-12)	College (1-4or 5+)	Do.	1 -	\mathcal{D}	adela La	. Chapl
V	tygie tr		17. Father's Name (First, Middle, Last)		TW	19 Methodo Nov	To (Simt Middle Ma	an rena	13/64_
=	the filed within 72 hours after death with the Maryla must Hygiene 1. And Hygiene 1. On the Hygiene 23a or 28a-f ahov other then "naturel", or flems 23a or 28a-f ahov event, the Madical Examinar must be notified at	Be	17. Painers Name (Pirst, Middle, Last)			A _ A	me (First, Middle, Mai	den Sumame)	1
20	Men	2	JOHN COLE	man		Hoda	nder	MYLLC	hes
<u>0</u>	d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relationship (T)	pe, Print) 1	9b. Mailing Addres	s (Street and Number or Ru	iral Route Number, C	ty or Town, State, Zip	Code)
_ ≥			Ada Olena	N (() U.e) 19	9.30 N.	the Horson	HENKI	ug Bal	6-MD21205
ก	s 1 and 4 Heal		20a. Method of Disposition		of Disposition (Na stery, crematory or	me of	Date 200	Location - City or To	own, State
E	y or		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State	Mo 4	COD IN 5	112/00	R. 1tm	MI
	nit. Pa artmen ortent: Injury		21. Signafure of Funeral Service Licens		20 Mama	al Address of Facility	15/00	Dallo,	141
20	permit. Pag Department Importent: any Injury once.		· / //.	" Sim	Vau	yw Core	enetra	seral So	wices
			qui w.		49	05 YOKK	Id Bol	to MD Z	RIZ
			23a. Part1. Enter the disease, or comp shock, or heert failure. List only o	ne cause on each line.	o not enter the mo	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	Myocard	ial In	farction			Criset and Death
	/Medical		resulting in death)	Due tower as a consequen-					
	Examiner			Aprtic	Stena	217			
	,	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen-					
je	ufek ansit	Examiner	Cause (Disease or injury that initiated events	Hupester	nsim				
	al-tra	×a	resulting in death) Last	Due to (or as a consequent	ce of):				
9	ite be executed. ysicien and ne burial-transit	cal							
00	cate phys the			d					
D	ling e as	Physiclan/Med	IF FEMALE:	20- 1/ 1				,	
X O	ath c	an	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy. 1 ☐ Live birth 2 ☐ Fetel dea	ath 3□Ectopic;			23d. Date of deliver	ery Day Year
-	he a ed t	Sic	1 ☐ Yes 2 INO	4☐Pregnant at time of death 9☐Unknown	5 ☐ Other (s	pecify)		World	Day 16a1
	by the	Ę	9 Unknown						
<u>_</u>	sth:	Ž	Part II. Other significant conditions co	ntribufing to death but not resultin	ofin fhe underlying	cause given in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
ğ	n sig	Completed by	End Stage	Renal Z	necasi	2	1 ☐ Yes	2√No 3 Prot	pably 4 ∐Unknown
200	v rec	ete		/			24a. Was an	24h Wara auto	psy findings available
Ď	e lay	E G					autopsy	prior to co	mpletion of cause of
=	cate pag	S					performed 1 ☐ Yes 2	No 1 ☐ Yes	2□ No
2	ortiffic ctor,	Be	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
_	nysic nis co dire	၉	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatient 3 D	OA Other: 4 Nursing H	lome 5 Residence	e 6 □Other (Specif	iy)
0	ig Pt tertt neral		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	b. Time of Injury	28c. Injury af Work?	28d. Describe how	njury occurred	
0	e full	atic	1 Natural 5 Pending 2 Accidenf investigation	(М	1 ☐ Yes 2 ☐ No			
2	Atte	‡	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home	, farm, street, facto	y, office	28f. Location (Stree	t and Number or Rura	I Route Number,
DIVISION OF	afte Dir	Certification:	4 Homicide	building, etc. (Specify)			City or Town, S	rate)	
	spite ours seral		29a. Certifier Certifying Phy	sicien: To the best of my knowled	dge death occurre	at the time, date and place	and due to the cours	a(e) and manner co	lalod
	Fund Fund Iteky	1CE	(Check only 2 Medical Exemi	iner: On the basis of examination and manner stated.	and/or investigatio	n, in my opinion, death occu	irred at the time, date	and place, and due to	the cause(s)
	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled bredor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29b. Signature and title of certifier		20	c. License number	204	Date signed (Month,	Day Year
	5 × 5 0		205. Signature and title of certifier	GIN SHY	7	N1/1/1/1/	290.	- 11 - 1	vay, real).
	/		· Inna	- vonero	10.	246447	<u> </u>	-12-030	
	'n		30. Name and address of person who c	ompleted cause of death (Item 23	a) (Type, Print)	,	4 . /	.44	
_	.)		NINA F. E	verett, MD	232.3	orleans	saltimo	c MD 2	1224
	Sta		31. Date filed (Month, Day, Year)	ompleted cause of death (Item 23 Were H. M.D. 36 Registrar's Signature	Agorage .	,	, (
	Registr		BHILL Z. Z. Z. Z. Z.	1 C 1 ACCUSA 1 1 (23) (24.6)	W N				I

to day.			rtificate of Death	Reg. N	1e2 0 0 6 5 9 3 40.
Physici		1. Decedent's Name (First, Middle, Last) Louis Peter Calomeris			av Year
/Medic Examin		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick	4	kc. County of Death Frederick
ineral rector		5. Social Security Number 1 Age (In yrs. last birthday, 12 F 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Control 18, Tay, Year	9. Birthplace (State or Foreig Washington D
Demit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Health and Mental Health and Mental Health and Mental Health and 23a or 28a-1 ehow important; if them 27 is marked other then "naturel; or iteme 23a or 28a-1 ehow eny injury or other traumatic event. It a Marilcal Examination to other traumatic event. It a Marilcal Examination to other traumatic event.	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L. Maryland Frederick	ocation Frederic	k	10d. Inside City Limit
	i Dire	10e. Street and Number 6309 Iverson Terrace North	10f. Zip Code 21701	10g. (Citizen of What Country? U.S.A.
	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: White
	To Be Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of workir DO NOT use retired)	ng	Kind of Business/Industry
		Elementary/Secondary (0-12) College (1-4or 5+) Broke 17. Father's Name (First, Middle, Last) Peter Calomeris	18. Mother's Name	(First, Middle, Maide engreanos	eal Estate en Su <i>mame)</i>
		19a. Informant's Name/Relationship (Type, Print) Georgette V. Calomeris/Wife 6300	ing Address (Street and Number or Rura Tverson Terrace	I Route Number City North, Fre	derick, MD 21701
		20a. Method of Disposition \times Derivation 3 \subseteq Removal from State St. 20b. Place of Disposition 4 \subseteq Donation 5 \subseteq Other (Specify)	osition (<i>Name of</i> prairies of charge the may 1	ate 200.	Location - City or Town, State Baltimore, MD
importe eny inju once.		The Contract of the Contract o	2. Name and Address of Faculity Keeney and Basf 106 Fast Church	Street	al Home Frederick, MD 2170
4 hours after death. Funeral Director: After this certificate has been signed by the attending physicien and polyticate has been signed by the attending physicien and polyticate has been signed for use as the burial-transit polyticate in p		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each time. Immediate Cause (Final disease or condition resulting in death) a	iter the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death
	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
	by Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	Certification: To Be Completed by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
				24a. Was an autopsy performed 1 Yes 2 2 1	
		examiner? 1 Yes 2 100 Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H			6 ☐Other (Specify)
		27. Manner of Death 1	Work? M 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	
eral Dire	Certif	4 Homicide determined building, etc. (Specify)			
within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1			
10	2	29b. Signature and title of the Verma M.O	29c. License number 7 5 7 7 6		Date signed (Month, Day, Year) 1AY 17, 2006
				//	11 1110

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Edward Coolahan MAY 16,2006 3:09 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Dec 2, 1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral №** M 2□ F Months 88 213-05-4063 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If Item 27 is marked other than "natural; or Items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County Itema 23a or 28a-f show recitate to notified at 1 Yes 2 No Towson Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 U.S.A. 800 Southerly Rd., #514 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11, Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 X Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer/Consultant Mechanical Engineering 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Coolahan Marion Κ. Zeiler William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If Item 27 Is eny injury or other trau once. 800 Southerly Rd., #514 Towson, MD 21286 Helen E. Coolahan-wife 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal Irom State 5/20/06 Druid Ridge Cemetery Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE 6 MONTHS /Médical Due to (or as a consequence of) Examiner PULMONARY EDEMA HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed . ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 20 No 2 No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and titlé of certifier 29c. License number munt 5-17-06 D 13272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 76/01 OSLER DRIVE TOWSON MARYLAND 212/04
3/ Registrar's Signature ROBERT STONER M.D. State Registrar

		1 - For State Registrar	State of Mar		artment of H ertificate of L			jiene _{eg. No.} 2006	5 15933
	dical	Decedent's Name (First, Middle BACBALA (1) 4a. Facility Name (If not institution,	X		4b. City, Town, or	Location of Deat	2. Date of Dea	th Day Year 11 2000 4c. County of Dea	
Funera Directo	al		AMULANO MEDIO	(In yrs. last birthday 69 Yrs.	BAYTA				rthplace (State or Foreign ountry) VA
a-f show	ctor	Usual Residence of Decedent 10a, State 10b, County MD NA		10c. City, Town or L					10d. Inside City Limits 1 Yes 2 No
ath with the	eral Director	10e. Street and Number 3704 West Sar				1229		U.S.A	. •
036 ours after de ral', or ttem Exerchment	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Marri	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Ispanic Origin? (Sin, Mexican, Puer	ipecify Yes or No- to Rican, etc.)	Specify:	
ING 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene. do other then "natural", or itema 23a or 28a-f show event, the Modical Exerciting Frust by notified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th grade		(Giv	edent's Usual Occupa e kind of work done d DO NOT use retired Nurs	during most of wo	rking	16b. Kind of Business State H	
ed ab	To Be	17. Father's Name (First, Middle, I) John Crowder 19a. Informant's Name/Relationsh		19b. Mai	ling Address (Street	Ada Le	me (First, Middle, e Lawso ural Route Numbe	·	Zin Code)
ore, Ma		Mark Cooley-S 20a. Method of Disposition 1 Burial 2 A Cremation 4 Donation 5 Other (S)	Son 3 □Removal from State	362 20b. Place of Disp	-	gton Av	oe, Balt	imore, M 20c. Location · City o Beltsvill	Id 21244 Town, State
Baltimo	once	21. Signature of Funeral Service I	C. Frugy	<u> </u>	March F/ 4300 Wab	<u>ash Ave</u>			21215 Approximate
Priysicia /Medica	al	sh ck, or hear fisease, or sh ck, or hear failure. List Immedate Cause (Final disease or condition resuring in death)	only one cause on each line		BPIRATOMY the ACCII			est,	Interval Between Onset and Death
1760, C. Ite be executed Extra by sicion and Ite burial-transit	al Examiner	Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	CONSEQUENCE OF):	the ACCII	DENT	404		10 D
Box 68 ath certifica ttending ph	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	***		23d. Date of de Month	livery Day Year
cords, P.O. I w requires that the deben signed by the estould be detached for the control of the	þ	Part II. Other significant condition	ins contributing to death but	not resulting in the	underlying cause give	en in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
al Records, 1: The law requires to icete has been signed to page 2 should be on	Completed							sy prior to med? death? 2 No 1 □ Ye	
of Vit Physician rithis certifinal	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		t 2 ER/Outpati		er: 4 ☐ Nursing F		ence 6 Other (Speomingury occurred	ecify)
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	pation not be 200 Block of Injur	y - At home, farm, s	Worl	k? Yes 2 □ No		treet and Number or F	dural Route Number,
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Co	29a. Certifier 1 X Certifyin (Check only one) 2 Medical	g Physician: To the best of Examiner: On the basis of e and manner state	examination and/or	ath occurred at the tim investigation, in my o	ne, date and place pinion, death occi	a, and due to the curred at the time, o	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	M.D.			646		29d. Date signed (Mon	th, Day, Year)
2		30. Name and address of person MICHAEL ABRA	AM 22.	S. GREEN		BAUTMU	ME, MD	21206	5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
2000	State Strar	31. Date filed (Month, Day, Year)		's Signature	rade!				

			. 101	partment of Health and Men ertificate of Death	tal Hygiene Reg. No	4 U U b	15934
	Physici /Medic		Decedent's Name (First, Middle, Last) Joseph A. Dec	Cerbo, Sr.		2006	3. Time of Death 2:20 P M
	Examir Funeral	er	4a. Facility Name (If not institution, give street and number) Quail Run Assisted Living 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Parkville y) If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min. (f	Date of Birth Month, Day, Year)	Baltimor 9. Birthple Country	ace (State or Foreign
	Director	Į.	212-09-7565 86 175. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or		ov. 29,1		sylvania d. Inside City Limits 1 Yes 2 No
	a within 72 hours after death with the Maryland Jene. r thao "natural", or Itame 23a or 28e-f ehow The Madical Ezaminar must be notified at	ral Directo	Maryland Baltimore 10e. Street and Number 6927 Broening Road	Dundal 10f. Zip Code 21222	10g. Ci	tizen of What Countri ited Stat	es
2-0036	72 hours after de natural', or Itam	d by Funeral	1 □ Never Married 2XX Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: WWII	Was Decedent of Hispanic Origin? (Specify if Yes, specify Cuban, Mexican, Puerto Ricar □ Yes	Yes or No- n, etc.)	14. Race - America Black, White, e Specify:	
-01717	filed within 72 ł Hyglene. rther than "nati	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired) Steel Worker		aind of Business/Indu	
aryland	should be nd Mental marked o	To Be	17. Father's Name (First, Middle, Last) Nicholas DeCerbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	18. Mother's Name (Firs Rosa Gi illing Address (Street and Number or Rural Rou	naccghli		Code)
тоге, ма	ges 1 and 2 and 2 and 2 and 2 and 2 and 2 and 27 is lift lift lift lift lift lift lift lift		20a. Method of Disposition 20b. Place of Disposition 1 1 1 1 1 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3	position (Name of Pate ematory or other place)		ocation - City or Tow	
Daill	permit. Pages. Department of the Important: If Its any injury or of others.	/		of Faith Cem. 5/20/20 22. Name and Address of Facility Duda-Ruck Funeral Hot 7922 Wise Ave. Dund	me of Du	and the second second second second	
8/60,	Physician Medical Examiner buriar transit in private in the puriar transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nter the mode of dying, such as cardiac or resp	piratory arrest,	í	Approximate nterval Between Onset and Death
O. BOX 68/	death certif e attending id for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month D	/ Day Year
cords, r.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco t	use contribute to the	
ital Reco	The ate h	e Completed	25. Was case referred to medical	1	24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of
VISION OF VI	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director Alter this certifical completely filled in by the funeral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner Death 1 Vatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury		_ // //	6 Other (Specify) ry occurred	
<u> </u>	pitel or Atte ours after de nerel Directo filled in by th	al Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify) 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	C	City or Town, State	, 	
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5	Sta	te"	30. Name and address of person who completed cause of death (Item 23a) (Type Suring All C Julia 2 Manual 31. Date filed (Month, Pay, Year) 2 2005 32. Pegistrar's Signature		de MD	2/22	2
	Registr		WAY Z Z ZUUG	porte			

68760,
P.O. Box
Records,
of Vital
Division

			Please	Type or Prin					-		_	
			For State Registrar	State of Ma	ıryland		artment of F tificate of a	lealth\and M Death		giene Reg. No.	006	15935
	Physicia	n	1. Decedent's Name (First, Middle, Las	t)					2. Date of De. Month	Day	Year	3. Time of Death
	/Medic			liam A.	Dowe	11	41. Oh. Taur	al analisa of Dogih	May 17		06 county of Deal	3:25 A M
	Examin	er	4a. Facility Name (If not institution, give Gilchrist Nursi				Tows	r Location of Death		40. 0	Balti	
	Funeral		5. Social Security Number 6. S	7. Age	(In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da	h v Vear)		thplace (State or Foreign
	Director		217-20-3110	M 2□F	78	Yrs.	WOTUIS Days	Tiodis Will.	March			Maryland
]	and II		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	mary	tor	Maryland B	altimore				Dundalk				1 ☐ Yes 2 ☒ No
	or 284	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	ountry?
	am w	ral	7540 Rabon Ave.	40.14	i- II C	10.1	Nas Bassas at at 1	21222			ed Sta	
	ritem ritem	Fune	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent 6 Armed Forces? 1 ☐ Yes 2 ☑ N				lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		Black, Whit	
0-00-0	ral', ou	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	I□Yes 2½ No	Specify:		S	Specify: W	Mite
ה ה	netur dicat	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	lent's Usual Occup kind of work done	during most of work	ing		d of Business	/Industry
7	wining ene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5 2 Years	+)		<i>00 NOT use retired</i> Maintena:	,			te of	
7	Hygir other ent, I	Be Co	17. Father's Name (First, Middle, Last)				Ma Incena.	18. Mother's Name	e (First, Middle,			
yiand	Menta Menta rrked ritc ev	To B						Laura 1	Dowell			
Mary	permit. Pages 1 and 2 should be liled within 72 hours arier death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I moportment if frem 27 la marked other than "netural", or Itema 23e or 28e-f show any injury or other traumatic event, the Medical Exercities must be notified at once.		19a. Informant's Name/Relationship (E-1		-	and Number or Rura	a <i>l Route Numbe</i> alk, Ma	-		
ა ა	1 and Health em 27 ther to		Mrs. Beverly A. 20a. Method of Disposition	DOMETT (MI	20b. Pla	ce of Dispo	Rabon A		Date Ma		nd 212 ation - City or	
	ages ant of l t: If it y or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation ☐ Other (Specifi		cen	netery, cren	natory or other plac	corp. 5/2	0/2006			aryland
	oorten / injur		21. Signature / Fineral Service Licer		11111	22	Name and Addre				-	
Ď	Deparation of the paratic of the par		1 Julian I	Veise			uda-Ruck 7922 Wise	Ave. Du	indalk,	Mary	land	21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
F	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Mult	tole	my	lloma					years
ı	Examiner			Due to (or as	a conseque	nce of):"						3
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a eoneeque	nea of):						
	oe executed cian and ourial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.								
٠ و		_	rooding in dodiny addi	Due to (or as	a conseque	ince or).						
200	nicate g phys	edic		d				2000				
X Q Q	eath certificate be e) attending physician for use as the buria	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,		23	d. Date of de	
o o	e deal the att	Physiclan/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
Ţ.	law requires that the death certilicate as been signed by the attending phys 2 should be detached for use as the		Part II. Other significant conditions of	ontributing to death be	ut not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?
g.	quires n sign	d by				_			1 🗆 `	Yes 2□	No 3□P	obably 4 Unknown
Vital Records,	aw requirats been si 2 should I	Completed							24a. Was		24b. Were at	utopsy findings available completion of cause of
ř	The ate h page	Com							perfo 1 ☐ Yes	rmed? 2 No	death?	2 No
VII a	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			t all Doa Ott	26. Place of Death			_/	14
0	Phys or this oral dia	: To	1 ☐ Yes 2 № No 27. Manner of Death	1 ☐ Inpatie 28a. Date of Inju (Month, Day		8b. Time of	I 3 DOA	4 Nuising Ho	me 5 Resi 28d. Describe I			city) MOSPICE
0	Attending I death. ctor: After y the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		(Year)	Injury		rk? Yes 2 ☐ No				
DIVISION	rr Atte ter de: irecto irecto	ertification;	3 Suicide 6 Could not be determined		ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location () City or Tox	Street and vn, State)	Number or Ri	ural Route Number,
	Mospital or Atteno 24 hours after death Funeral Director: etely filled in by the	O	CO. Coddies M. Codding D	veision. To the best	of one lemone	ladma daath		data and place	and due to the			
	To the Hospital or Attending Physician: within 24 hours alter death as a fire death in certific completely filled in by the funeral director, completely filled in by the funeral director,	edical	29a. Certifier Certifying Pt (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	on and/or in	vestigation, in my	ppinion, death occurr	red at the time,	date and p	place, and due	to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	0 -			29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)
			Man	Mary)			V	28202		1 1 1/1	7 1)	2006
6	7		30. Name and address of person who	completed cause of d	eath (Item 2	23a) (Type,	Print) 6601	N. CHARL	ESUTRE	ET		
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signatu	ire /	10005	UN TIE.	21207			
	Regist		MAY 2 2 200	6 Pegistra	2000	A STATE OF	Charles .					

			1 - For State Registrar	State o	f Marylar		artment rtificate				lental Hyg	giene	006	1593	36	
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ath		3. Time of De	ath	
	Physici /Medio		WILLIAM J. DIETE	R, SR.							MAY	18	2006	9:30P	М	
	Examin		4a. Facility Name (If not institution, giv		mber)		4b. City, T	own, or	Location of	of Death		4c. Co	unty of Death)		
			5069 White Marsh		7 4 //	for a foliation of	Ros	eda]	Le If Under	24 Hza		Baltimore				
П	Funeral Director		5. Social Security Number 6. S 217~36~4381	ex XOXM 2□F	7. Age (In yrs. 88	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day	place (State or Fo	oreign			
			Usual Residence of Decedent								Nov. 1	ryland				
	how		10a. State 10b. County		10c. C	ty, Town or Lo								10d. Inside City L		
	Ba-1	cto	Maryland Baltimor	e		Roseda	le~Ba	ltim	nore,	Md.				1 ☐ Yes Ž	∆ No	
	permit. Pages 1 end 2 should be tiled within 72 hours after deeth with the Maryland Depertment of Heath and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or items 23s or 28s-1 show entry hiury or other traumatic event, the Medical Examinar must be notified at ance.	Director	10e. Street and Number 5069 White Marsh	Rd			10f. Zip (21237			10g. Citizen US <i>F</i>	of What Cou	intry?		
	ns 23	erai	11. Marital Status		edent Ever in I	IS 13 V	Was Decede			ain? (Sne	ocify Ves or No-		Race - Ameri	ican Indian		
(0	riten	Armed Forces? If Yes, specify Cuban, N									Rican, etc.)		Black, White	, etc.		
93	rel', o	by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve ates:		1 ☐ Yes 2	No	Specify:			Sp	ecity: Wh	ite		
5-0	72 h	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer								na	16b. Kind	of Business/Ir	ndustry			
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use	retired,)			C = 1	£ []			
22	Hygie Hygie ther t nt, in		8 yrs. 17. Father's Name (First, Middle, Last)	N/A		Farmer 18. Mother's Name (Fir					(First Middle			ployed		
Maryland 21215-0036	d be entai ked o	To Be	Jacob A. Dieter								Kraft	maiden Sui	marrie)			
ary	should Ind Mening Marke	ř	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a			I Route Numbe	r, City or To	wn, State, Zi	p Code)		
	alth a		William J. Diete:	r, Jr.	(Son)	5069	9 Whit	e Ma	arsh	Rd.	Baltimo	re, M	d. 21	237		
Baltimore,	of He of Herritan		20a. Method of Disposition 1 🔀 Burial 2 🔲 Cremation 3 🗔	Removal from		Place of Dispo- cemetery, cren	sition (Name	e of er place	9)	D	ate	20c. Locati	ion - City or T	own, State		
Ĕ	Pages ment of l		4 ☐ Donation 5 ☐ Other (Specif	1 /	St	. Jos.	Ch. C	eme	tery	5~24	~2006					
Ball	Depentition Depentition of the contraction of the c		21. Signature of Funeral Service Lorr	1500	1	22	. Name and		s of Facility Fune:		1		elair F			
	40 = 0 d		hallen 1	()									ore, Mo	. 21236		
			23a. bart . Enter the arsease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on e	aused the dea ach line.	0 1	1 1 1		such as	. 6	7			Approximate Interval Betwee Onset and Dear		
	Physician /Medical		disease or condition resulting in death)	a Div	era		idne	3	130	rle.	me si	con	long	2/10		
	Examiner				(or as a consec	quence of):	i Ou	an	1/21	2 1	> la	· ren	June 1	Non	mill	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence of);			, ,		2		1.12	/ / /		
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Ŏ,	ate be exe hysicien ar the burial-t	EX	resulting in death) Last	Due to	(or as a consec	uence of):										
8760,		dical		d												
9 X	death certific e attending p id for use as	/Me	IF FEMALE:	23c. If yes, out	come of preon	ancv										
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth 2 ∏ Feta	ul déath 3 □	Ectopic pred					23d.	Date of delive Month	ery Day Year	r	
O.	that the deatt ed by the atte detached for	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn			(a.i.o. (apo.									
ď.	The law requires that the ste hes been signed by th bage 2 should be detache	by Physician/Med	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in the un	derlying cau	ise give	n in Part I.		23e. Did to	bacco use d	contribute to t	he cause of death	h?	
ğ	aquire en sig	edt	Congesta	N CO	inde.	omyo	pat	tu	7		1 🗆 Y	es 2□N	o 3□Prot	oably 4 Dunkr	Town	
ecc	e law re hes be ge 2 sho	Completed	Newmol	1 Hy	poth	yroc	lug				24a. Was a		4b. Were auto	opsy findings avai	ilable	
<u>ت</u>	The sete h page	Con	Jones for	ulla	temo	vettais	rtwlb	12	espo	nse	perform		death?	2□ No	9 01	
Vita	lcian: sertific ector,	Be	25. Was case referred to redical examiner?	Moss tet.				lai		of Death	(Check only on	9)				
of	Physician: The la r this certiticete hes aral director, page 2	2	1 Yes 2 No 27. Manner of Death			ER/Outpatient			4 C I I I I I		ne 5∃Reside			(y)		
on	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation		of Injury th, Day Year)	Injury	M 28	Work	at ? 'es 2.∐N		8d. Describe ho	ow injury oc	curred			
Division of Vital Records,	Attendi r death. cctor; A	fica	3 Suicide 6 Could not be	28e. Place	of Injury - At h	ome, farm, stre					8f. Location (St	treet and Nu	mber or Rura	al Route Number,		
á	s effer si Dire	Certification:	4 Homicide determined	buildi	ng, etc. (<i>Specii</i>	(y)					City or Town					
	Hospital 24 hours e Funersi I	edicai	29a. Certifier 1 Certifying Ph	iiner: On the bi	asis of examina	wiedge, death	occurred at	the time	e, date and inion, deat	d place, a	and due to the ca	ause(s) and ate and place	manner as s	tated.		
	To the Hospital or Attending Ph within 24 hours elter death. To the Funersi Director: After th completely tilled in by the funeral	Med	one) 29b. Signature and title of certifier	and manr	ner stated.	2			number				gned (Month,			
	. , , ,		Michne	10	Thene	eni	0	>	00	27					10	
	8		30. Name and address of person who	completed caus	e of death (Iter	n 23a) (Type, F	Print)	1	1/1		693 4 BA	11	1 . /	1000	P	
	7		Michael A.1	ty 1E	121-1	1.65	30 W	ne!	hen	else	re Ba	Stom	mm	2120	16	
	Sta Registr		31. Date filed (Month, Day, Year)	6 32. R	egistrar's Signa	ature	Single Control									

wm. J. DieteR

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:08 PM MELIA Mar 2006 /Medical 4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore If Under 24 Hrs. If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1□M 2**D**F **Funeral** Hours 220-50-255 Yrs 56 Director Jan 27 1950 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "neturel", or items 23a or 28a-f show or other treumatic event, the Madical Examinar must be notified at Completed by Funeral Director MD 1 Yes 2 No ISALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2619 U.S.A 215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "netural", or its 1 Tes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BIACK 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, permit. Pages 1 and 2 a Department of Health ar Important: if item 27 is eny injury or other treu paughler 2619 CLY BURN AVE. BALGO. MD. 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-26-06 4 ☐ Donation 5 ☐ Other (Specify) MEM 21. Signature of Fune II Service Licensee 22. Name and Address of Facility Fun 3512 FreDerick 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Hhknown 1 Tyes 2 TNo this certificate hes been s al director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an autopsy performed? 1 Yes 2 110 To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient Certification: To 1 Inpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D56418 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W Belvedere Ave Baltimore K Tonya Mason 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	•	For State Registrar	State of Maryland		rtment of F			ene 2006	15938
Physici		Decedent's Name (First, Middle, Last) SHIRLEY	G.		EISEMAN		2. Date of Death	2006 Year	3. Time of Death 11:00 PM
/Medi Examir		4a. Facility Name (If not institution, give sta 3601 CLARKS LANE				r Location of Deal		4c. County of Dea	N/A
Funeral Director		377 01 0002	7. Age (In yrs. la	38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bi	rthplace (State or Foreign lountry) MD
ehow	ō	Usual Residence of Decedent 10a. State 10b. County MD N/A		, Town or Lo				,	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the hard a or 28a-1	Director	10e. Street and Number 3601 CLARKS LANE	i		10f. Zip Code	21215	10g	. Citizen of What C	Country?
ified within 72 hours after death with the Maryland Hygiene. Wher then "natural; or Itama 23a or 28a-f ehow after the Madical Examiner must be notified at the Madical Examiner must be notified at	Funerai		2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No		Vas Decedeni of H Yes, specify Cuba		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
2 hours a	þ	3 N Widowed 4 □ Divorced 15. Decedent's Educa (Specify only highest grade	If Yes, Give Year or Dates:	16a, Deced	☐ Yes 2 X No	Specify:	rking 16	Specify: b. Kind of Busines	WHITE
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturany or other traumatic event, the Madical page.	Completed	Elementary/Secondary (0.12)	College (1-4or 5+)	HOMEN	kind of work done DO NOT use retired MAKER				OWN HOME
should be fill and Mental Hy imarked oth	To Be	17. Father's Name (First, Middle, Last) JOSEPH		GOODMA		IDA	me (First, Middle, Ma		PLAINE
and 2 sho ealth and m 27 ls m		JOEL EISEMAN / SO	N	8802	HOWARD F		NE - BALT	IMORE, MO	21208
Pages 1 ment of H ant: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	IMORE	sition (Name of natory or other place HEBREW C	CEM 05/1	19/2006		RSTOWN, MD
Departiment important in poort		21. Signifure of Funeral Service Lines for	gen	89	900 REIST	ERSTOWN	DL LEVINSO ROAD = PI	KESVILLE,	MD 21208
Physician		23a. Part1. Enter the disease, or comproshock, or heart failure. List only one immediate Cause (Final disease or condition	cause on each line. CORONARY AR			ng, such as cardia	c or respiratory arresi	,	Approximate Interval Between Onset and Death
/Medical Examiner	_	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ						
be executed sician and burial-transit	Examine	rr any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequ						
licate be e physician s the burie	dicai	C d.							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
quires that	by	Part II. Other significant conditions cont DIABETES MELLITUS	ributing to death but not resu	ilting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac 1 ☐ Yes	_	o the cause of death? Probably 4 □Unknown
The law red ate has bee page 2 shor	Completed						24a. Was an autopsy performe	d? prior to	autopsy findings available completion of cause of
nysician: nis certifica director,	To Be (25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	soital: 1 Inpatient 2 E	ER/Outpatien	t 3 DOA Oth		alh (Check only one)	e 6 □Other (Sp	ecify)
ending Pl eath. or: After th	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe how	inju <i>r</i> y occurred	
ital or Att urs after d ral Direct	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify				City or Town,	State)	Bural Route Number,
the Hosp hin 24 hou the Fune mpletely fil	Medical	(Check only 2 Medical Examine one)	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death ion and/or inv	restigation, in my o	pinion, death occi	urred at the time, date	and place, and du	e to the cause(s)
5 W TO			of copy, w			19604 	290	Date signed (Mor	nn, Day, 18di)
10		30. Name and address of person who con Pubern A. Be	10. AD #450: U	CATT Fel	hed Liken	lle, 4 210	53		
St Regist	ate rar	31. Date filed (Month, Day, Year) MAY 2 2 200	32. Registrar's Signat	y Ja	will !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a,perFH,g855,5/22/06 TT Department of Health and Mental Hygiene | | | | 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MAY 17, 2006 **Physician** 2:10 P FEIKIN EDITH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 816 WOODGLEN PLACE BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08/25/1914 Birthplace (State or Foreign Country) 5. Sociaf Security Number 7. Age (In yrs. iast birthday) **Funeral** Months 1 M 2 F 91 MD Yrs. 213-03-5001 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code or iteme 23a or USA 816 WOODGLEN PLACE 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Baltimore, Maryland 21215-0036 WHITE 3 X Widowed 4 ☐ Divorced "naturai" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "ne any injury or other traumatic event, Ita Madia once. Elementary/Secondary (0-12) College (1-4or 5+) CHILDREN'S STORE OWNER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **SOPHER** SAPERSTEIN SAMUEL JENNEY 9 Informani's Name/Relationship (Type, Print)
EDTH FEIKIN / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 WOODGLEN PLACE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 5/19/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal 22. Name and Address of Facility SOL LEVINSON & BROS., INC. vice Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Causa (Final disease or condition resulting in death) Dementia **Physician** years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day ò in the past 12 pronths? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Stenosis 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes b lirector, page 2 si autopsy performed 1 Yes 2. No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice itely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO May, 18, 2006 D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST, Suite 209, Towson, MD 21204 6565 North Charles Black 32 Registrar's Signature 31. Date filed (Month Day, Xear) State 2006 Goods Registrar

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- 1. The state of the state of	Regist		31. Date filed (Month, Pay, Year)	ZUU6	egistrar's Signa	C B									

4b. City, Town, or Location of Death

May

18,

2006

4c. County of Death

	For	State of Maryland / Department of Health and N	/lental Hyg
-	For State Registrar	Certificate of Death	F
1. 0	Decedent's Name (First, Middle, Last)		2. Date of Dea Month

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4a. Facility Name (If not institution, give street and number)

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3. Time of Death

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Maily Idilio ZIZIS-DOUGO 4.2 should be filed within 72 hours after death with the Maryland 4.2 should be filed within 72 hours after death with the Maryland 4.2 should be filed "Tatural", or items 23s or 28s-1 show 1.1 should be then "retural", or items 23s or 28s-1 show 1.2 should be then "retural".
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1

Physician

/Medical

Examiner

6501 Westland Road Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Yrs 86 578-24-8167 December 7, 1919 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Bethesda Montgomery Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20817 6501 Westland Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💹 No Specify. þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Thomas Harvey A. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jon R. Grimm /Son 25777 Whiskey Creek Road, Hollywood, Maryland 20636 permit. Pages 1 and Department of Health Important: If Item 27 eny Injury or othar fr 900. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition May 20, 1 Burial 2 Cremation 3 Removal from State Montgomery Crematorium, Inc 4 Donation 5 Other (Specify) Bethesda, Maryland 2006 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M01305 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐ Yes 2 XNo detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 X No or Attending Physicien: rector. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \text{ Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No ٥ 1 🗆 Inpatient 2 ER/Outpatient 3□ DOA funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. M investigation 2 Accident filled in by the after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) Medic 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D29142 May 20, 2006 00 X 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue, #205, Silver Spring, Maryland 20902 Charles R. Boice, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAY 2 2 2006

		State Registrar Amend ITT 1. Decedent's Name (First, Middle, La	st)	I ROLL		. VV. 1			2. Date of De Month	ath Da	у `	Yeer	3. Time o	
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amin	_	4a. Fecility Name (If not institution, giv	e street and number)	1 A=2			Location o	f Death		1	County of			
		HOWARD COUNTY				LUH		14 Hro	2.5		OWAI		100	
eral ctor		none	Sex 7. Age (In yrs	. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 5 /12 /6		1	9. Birthp Coun	ilace (State htry) Y Z A N D	or Foreign
_	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation							1	0d. Inside C	ity Limits
3	ō	MD	Po1	timore									1 ∑ Yes	2 🗆 No
event, the Medical Examinar must be notified at	Funeral Director	10e, Street and Number	Dai	LUTINOTE	10f. Zip	Code				10g. Cit	tizen of W	nat Coun	ntry?	
3	<u>i</u>	1528 N. Wolfe St	raat		212	13				IJ	SA			
Tage .	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)		14. Race		an Indian,	
in in	Ē	1 ☑Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🖾 No		1 ☐ Yes 2			, Puerto i	rican, etc.)			, White,	elc.	
Exa	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		To res 2	5 170 IAO	зр о спу.			-	Specify:	b1a	ck	
lical	Completed by	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give	dent's Usua kind of wor	rk done d	lurina most	of workir	ng	16b. K	ind of Bus	iness/Ind	dustry	
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Nen	Be	17. Father's Name (First, Middle, Last)		unk				(First, Middle	, Maider	Sumame)		
matic e	ဥ						Kia N				-	4 1 1		
2		19a. Informant's Name/Relationship	•						Route Numb				Code)	
ar tr		Kia N. Gentry/mot					Stre		altimo				Chata	
Department of Health Important: if item 27 i any injury or othar tra once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 図 Other (Speci	Removal from State	Place of Dispo cemetery, cre	matory or o	ne or ther place	9)	U	ate	20c. L	ocation - C	ity or io	own, State	
any inju		21. Signature of Funeral Service Lice	nsee	r		Ana	tomy	Boar	i 655 v	Л. В	altim	ore	Stree	t
		23a. Part 1. Enter the disease, or con shock, or heart failure. List only	plications that caused the dea		Baltin ter the mod					rrest,			Approxima Interval Be	te tween
		Immediate Cause (Final		O Par	1	.00	D.L.	wks					Onset and	Death
cian lical		disease or condition resulting in death)	a. by Strem Due to (or as a conse		malw	un	24	WNS				-		_
iner			Resignation		Trect	8	mdn	ama K)					
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		1116 25		TIMIL	2491						
ansit	Examiner	Cause (Disease or injury that initiated events	· Palemona	NR	Haen	mon	hel 9	0.				1		
burial-transit	cal Exa													
for use as the buria														
esn .	Z N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pr	egnancy					23d. Date			Year
loj pa	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of 9 ☐ Unknown		Other (sp						Mont	.11	Day	rear
tached	, p	9 Unknown												1-1-0
should be deta	d by Physician/Med	Part II. Other significant conditions	contributing to death but not re	sulting in the i	underlying c	ause give	en in Part I.						ne cause of pably 4 🗆	
shou	ete								24a. Was	an .	24b. W	ere auto	psy findings	available
CV	Completed									ormed?	pr de	ior to cor ath?	mpletion of	cause of
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rector, p	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only		• 🗆			
ig G	7.	1 Yes 2 No	28a. D te of Injury	ER/Outpatie	-	28c. Injury	4 🗀 140		ne 5 Res 28d. Describe				y)	
funer	no!	1 XNatural 5 ☐ Pending	(Month, Day Year)	Injury	м	Work	k? Yes 2 🔲			,	,			
the	icat	3 ☐ Suicide 6 ☐ Could not	be One Blace of Injury At	home, farm, si				-	8f. Location	(Street al	nd Numbe	r or Rura	I Route Nur	nber,
in by	Certification:	4 Homicide determined	building, etc. (Spec	cify)	irooi, radior,	y, 511100			City or To					
completely filled in by the fu	Medical C	29a. Certifier 1 € Certifying P	hysician: To the best of my ki iminer: On the basis of exami	nowledge, dea	th occurred	at the tim	ne, date an	d place, a	and due to the	cause(s	and man	ner as s	tated. the cause(s)
pleto	ledi	one)	and manner stated.	, 11 0	000	c. License	- aumbar			20d D	to cianad	(Month	Day, Year)	
200	2	29b. Signature and title of certifier		- 4.0	290	2:				290. 00	4 1	1	Day, Ioai,	
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			For State	State of Maryla		rtment of F			2001	5 15944
	8,9	ы	Registrar 1. Decedent's Name (First, Middle, La	st)	Cen	ilicate oi	Dealli	2. Date of De		3. Time of Death
	Physici /Medio	cal	Joseph Clav 4a. Facility Name (If not institution, giv	ence that o	\sim	4b. City Town o	or Location of Dea	May	20 200 4c. County of D	
	Examin	ier	Battimore Rehabilit			4b. City, Town, o	fime	ın	4c. County of D	IA-
. i	Funeral Director		5. Social Security Number 6. S 220-04-8946 1 Usual Residence of Decedent	iex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th Year 9.1	Inthplace (State or Foreign Country) Maryland
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural", or itema 23a or 28a-f show ther then "madical Ezariti er madical Le rodified al	tor	10a. State 10b. County Maryland	A 10c. C	City, Town or Loca	Baltin	wre		,	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	I Direc	10e. Street and Number 4815 Lindsan	I RA.		10f. Zip Code	21229		10g. Citizen of What	Country?
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: yor Itema 23a or 28a-f show important: Item 27 is marked other then "natural; yor Itema 23a or 28a-f show eny injury or other traumatic event, the Maritsal Example or must be notified at DDCs.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☑ No	lf '	Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	Black, W	merican Indian, hite, etc.
200	2 hours a atural', o	ted by	3 Widowed 4 Divorced		16a. Decede	Yes 2 No	Specify:		Specify: L	SS/Industry
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2 2	ould be filed Mental Hygi arked other atic event,	To Be	17. Father's Name (First, Middle, Last, Joseph Hatto	\sim			_	me (First, Middle,	Maiden Sumame)	
Mai	ind 2 sho alth and N 27 Is ma or trauma		19a. Informant's Name/Relationship (Type, Print) -Wife	19b. Mailing 4-81	Address (Street	and Number or R	ural Route Number	Timore,	laryland
nore,	ages 1 a ant of Hei at: If Item y or othe		20a. Method Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Place of Disposit cemetery, crema	tion (Name of atory or other place	сө) 5 -	Date 22/0/2	20c. Location - City	or Town, State
	permit. Pag Department Important: I eny injury o		21. Signature of Fuhral Service Lice		22.	Name and Addre	ess of Facility Par	Kertu	regal Hon	4 P.A. 21229
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de-	ath. Do not enter	the mode of dyir	ng, such as cardia	c or respiratory a	rest,	Approximate interval Between
£ -	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metest Due to (or as a conse	atic L	ung (ancer			Onset and Death
	Examiner	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Aspirat Due to (or as a conse		neumo	1010			
(executed in and ial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	equence of):					
5	cate be physicie the bur	dlcal E	(_ d						
o Xoo	ith certific tending p or use as	an .	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		ctopic pregnancy	/		23d. Date of Month	
5	at the dea by the at tached for	Physician/M	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown	death 5 (Other (specify) _			Monui	Day Year
ecords, r	quires tha	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the und	lerlying cause giv	ven in Part I.		obacco use contribute res 2□No 3□	to the cause of death? Probably 4 Denknown
מפט	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed							rmed? prior t	autopsy findings available o completion of cause of es 2 No
A ICA	ician: Sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o	2 No 1 Y	es ZEINO
5	g Phys erthis eral dir	n: To	1 ☐ Yes 2 DNo 27. Manner of Death	28a. Date of Injury	ER/Outpatient	3 □ DOA Oth 28c. Injur Wor	4 🗀 Nursing r		dence 6 Other (S	Decify)
	tending leath. tor: Aft the fun	catlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	a	Injury	M 1 🗆	Yes 2 □No			
2	ital or Al irs after c ral Direc led in by	Certification;	4 Homicide determined	building, etc. (Spec	cify) 			City or Tov		
	ne Hosp 24 hou ne Fune vietely fil	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	nysician: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death on ation and/or inve	occurred at the tir stigation, in my o	me, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
)	To the within to the comp.	Ň	29b. Signature and title of certifier	Waile I	I MD	29c. Licens	ie number		29d. Date signed (Mo	nth, Day, Year) 2006
	5		30. Name and address of person who Geovas E. Wic	completed cause of death (Ite	em 23a) (Type Pr	Raven	Bouler	and B	altimore	MD. 21218
	Sta Registr		31. Date filed (Month, Day, Year)	Z. Hogional o olg	nature)		, , , , , ,

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** MAY 15 2006 11:35 PM NATHANIEL MASON HUNSAKER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY BETHESDA NATIONAL NAVAL MEDICAL CENTER Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 11XIM 2□ F None Maryland Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County Show in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Maryland | Montgomery Gaithersburg 1X Yes 2 □ No Direc 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20879 United States 431 Christopher Avenue, T-3 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black White etc. 1[™] Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny light yor other treumatic event 90cg. Mandy Goodman Hunsaker John D. Hunsaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 431 Christopher Avenue, T-3 Gaithersburg, MD 20879 Mandy Goodman Hunsaker/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 1 Burial 2 □ Cremation 3 □ Removal from State 19, 2006 All Souls Cemetery Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home Rockville, Inc. 300 West Montgomery Awarus 21. Signature of Funeral Service Licensee Chaples. West Montgomery Avenue 20850-2805 John f. M00092 Rockville, Maryland Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician POTTERS SYNDROME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician by Physician/Medical as the 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No this certificate 1 ☐ Yes 2**X** No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဠ 1 ☐ Yes 2💢 No 1 X Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After t Injury 5 Pending investigation 1 XNatural 1 Tyes 2 No death. nerel Director: / 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 6 within 24 hours a
To the Funerel C 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29c. License number ertifiè 29b. Signature and tile of 2006 0116016138 (VA) 1 completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600 MC MILLER CAELA R. USA 31. Date filed (Month, Day, Year) MAY 2 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Lest) Day 2006 **Physician** April 30, 11:50 PM Willie Hickman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring M | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | 8. Date of Birth | (Month, Day, Year) Millineum Health & Rehab Montgomery If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1 № M 2 🗆 F Yrs 53 July 12, 1952 South Carolina 249-86-9451 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Bel Pre Road 20906 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 凶 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ Year or Dates: 174-79 3 Widowed 4 Divorced black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Landscaping U.S. Park Service 12 None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be ၉ Jouions Hickman 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ebony McNeill/daughter 409 Old Stage Road Glen Burnie, MD 21061 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ②Other (Specify) in state Ronald 9. Wa 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MĎ 21201 men proceding that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or complicate the disease, or complicate the complex transfer in the complex transf Immediate Cause (Final disease or condition resulting in death) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 00 that initiated events resulting in death) Last Due to (or a aconsequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Lear) 27. Manner of Peath 28b. Time of Certification: 1 | Natural 2 | Accident 5 Pending investigation NIF 1 🗌 Yes IV 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A NID 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person completed cause of death (Item 23a) (Type, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 2 2006

Registrar

Funeral

Director

"netural", or items 23e or 28a-f show edical Examiner must be notified at

other then "netur

traumetic event.

Important: If item 27 any injury or other tr. once.

Department

Physician

/Medical Examiner

physician and s the burial-transit

attending p as

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has page 2

certificate

this

After

efter death. Director: Aft

within 24 hours eft To the Funeral Di completely filled in

director.

the

in by

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "netural", or items 23e or 28a-f show

Baltimore, Maryland 21215-0020

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 106

15 15947

			Registrar			$C\epsilon$	ertificate	of L	Death			Reg. N	lo.		10371
			1. Decedent's Name (First, Middle	Last)							2. Date of D	eath D	av Ye	ar	3. Time of Death
	Physicia /Medic		PHYLLIS VIRGIN	NIA JONES	3						Month	AY "	i'a, zởi	36	9:40 P M
,	Examin	_	4a. Facility Name (If not institution, Saint Joseph	give street and no Medica	al Cen	ter	4b. City, To	own, or		ol Death	n	4	c. County of E	eath Lti	more
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthda		Year Days	If Under Hours	24 Hrs. Min.	8. Date of 8 (Month, L	Birth	9.	Birthpl Coun	ace (State or Foreign
	Director		226-48-9053	1 ☐ M 2 🖾 F	6	7 Yrs.	MOTILIS	Days	riouis		11-15-				INIA
	p.		Usual Residence of Decedent		1.0										
	arylar	-	10a. State 10b. County		100.0	ity, Town or	Location							10	Od. Inside City Limits
	Ba-f	cto		burg Co			LYNCHB	URG							1 X Yes 2 No
	or 2	Director	10e. Street and Number				10f. Zip C	ode				10g. C	itizen of What	Coun	try?
	23a		706 FEDERAL ST.						504_				5.A		
	ar de	Funeral	11. Marital Status	Armed F		U.S. 13	. Was Decede If Yes, specifi	nt ol His y C <mark>uba</mark> r	spanic Or n, Mexicai	igin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	10-	14. Race - A Black, V		
3	filed within 72 hours after death with the Maryland Hygiene. Hysiene. Instural', or terme 23a or 28a-f show wit, the Madical Exambar must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, G	2 ∏ No live		1 🗆 Yes 2	XNo	Specify:	:			Specify:		
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2	within 72 ho piene. r then "natur rre Modical	Completed	(Specify only highest	grade completed		(Giv	e kind of work DO NOT use	done di	uring mos	st of working	ng	100.	Kind of Busine	iss/inc	lustry
4	a filed within I Hygiene. other then	шc	Elementary/Secondary (0-12)	College	(1-4or 5+)	dome							CELE		
3	be filed tal Hygi d other event, I	Ö	17. Father's Name (First, Middle, L	ast)		- dome:	SCIC		18. Moth	er's Name	(First, Middl	le, Maide	SELF in Surname)		
2	o d a d	To B	CHARLIE JONES							TDEN	E JONE	r.C			
_	GDEE	_	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Ma	ling Address (Street a	nd Numb				or Town, Stat	e, Zip	Code)
Ž	od 2 Ith a 27 Is		JANICE JONES/DA	UGHTER		706	FEDERAL	ST.	. APT	r 36	LVNCHE	RIIRG	. VA 24	504	
נ <u></u>			20a. Method of Disposition			Place of Dis	oosition (Name ematory or oth	of			ate		Location - City		
2	Page ent o nt: If ry or		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (Sp				REMATOR		1	5-20	-2006	DAT	mTMODE:	1 1	ID.
	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service L	• •	1111		22. Name and	Address		ity			TIMORE		
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	/Medical		disease or condition resulting in death)	_ a	(or as a conse									-	
	Examiner			CARI	DIOGEN		OCK								
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			23b. Was decedent pregnant in the past 12 months?	23c. If yes, or 1☐Live	utcome of pregration to the pregration of the pr		□Ectopic preg	nancy					23d. Date of		•
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	The	Con									1 Tes	formed? 2 0 N	death	17	2 No
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-	I or Attending Physician: The I after death. Director: After this certificate he d in by the funeral director, page	Certification:	4 Homicide determine	ned 286. Plac build	e of Injury - At I ling, etc. <i>(Sp</i> ec	nome, tarm, s sify)	treet, lactory, o	office		2	City or To	own, Stai	te)	Hurai	Route Number,
•	pital ours eral filled		29a. Certifier 1 Certifying	Physicien: To th	e best of my kr	owledne de	th occurred at	the time	e date an	nd place a	nd dup to the	2 221150/	a) and		and a
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter or the Funeral Director. The fine this certificate has been signed by the formpletely filled in by the funeral director, page 2 should be detached for the completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical E	xeminer: On the and m	basis of examir	ation and/or	nvestigation, in	n my op	inion, dea	th occurre	d at the time	, date ar	nd place, and	due to	the cause(s)
	ro th within ro th	Me	29b. Signature and title of certifier	K. As	b-				number				ate signed (M		
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3	1		30. Name and address of person v				e, Print)					1	10/		200
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Registrar

MAY 2 2 2006

William Francis Jamison

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Take of Maryland / Department of health and Mental h		g. No. 200	s isol
Physiciai Medical Examin		1. Decedent's Name (First, Middle, Last)	Date of Deat Month	Day Year	3. Time of Death 2000 hrs
medical Examin	G	William Francis Jamison 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	May 11, 20	4c. County of Deat	
		2508 Edgewater Ave Baltimore			,
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.		h(MM/DD/YYYY) 9. Bii Forei	nn
Director		212-36-1031 1XM 2 F 75 Yrs.	Octobe	r 19,1930 c	untry)Maryland
апу	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
*	닐	MD. Baltimore Dundalk		A	1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
th the 1		6761 Woodley Road 21222		USA	
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. Armed Forces) If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
ifter de		1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: Wh	ite
hours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the complete of the compl		16b. Kind of Business/	Industry
36 tin 72 than "	Completed	12 years College (1-4 or 5+) Sales Publicist	ou,	Canital I	Dogovala O
5-00 ed with tygiene other i	튅	17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle, M	Capital I	records
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cevent, the Medica	Be	The state of the s	.chardso		
O sh and is is is	٤	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R Brenda Kelly Sister-In-Law 107 Overture Way, Cen			
	-	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
MOFE ages 1 ent of H nt: If i		Burial 2 X Cremation 3 Removal from State Bayview Crematory May	22,2006	Baltimore	
Baltimore, permit. Pages I at Department of He Important: If the injury or other tr	1	4 Donation 5 Other Specify			
	-	21 Signatur of Funeral Service Lifentee 22 Name and Address of Facility Connelly Funeral H 7110 Sollers Point	Road,	Dundalk, MD.	
Physician /Medical		234. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Death
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Box 68 e death certif the attending ed for use as	S	1 Yes 2 No 9 Unknown 9 Unknown 5 Other (Specify)			1
that the red by the detache	y Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	he cause of death?
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Division of Vital Records, P.O. and or Attending Physician: The law requires that the rest after death. "In Director: After this certificate has been signed by the funeral director, page 2 should be betach."	m̃	25. Was case referred to medical examiner? 1 Yes 2 No Cherry 1 DOA Otherry Nursing		tesidence 6 🗸 Other	Scano
of \ng Phy	٩	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	- Courte
ISION OF Attending Ph ar death. ector: After t by the funeral	Certification:	Natural 5 Pending D 1 7/11 /0006 D 1 0 00 1 1 Yes 24- No	ubject in	volved in veh	icle fire
Division pital or Attencours after death teral Director: filled in by the	≗	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St	reet and Number or Ruitel 2400 Edgewa	al Route Number, City
Hospital 24 hours Funeral tely filled		29a Certifier			
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as a completely find in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the funeral filled in the filled in the funeral filled in the funeral filled in the funeral filled in the filled in the funeral filled in the	Medical	(Check only one) 1 Certifying Physician: To the best or my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated	the time, date a	nd place, and due to the	ecause(s)
	ĕ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor.	th, Day, Year)
(U)		Theodore M. Kyrus O.C.M.E.		May 12, 2006	
0		30. Name and address of person who completed cause of death) (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
Stat	te	31. Date filed (Month, Day, Year) 32. Rehistrar's Signature			
Registra		MAY 2 2 2006 Region to poster			
DHMH 17 Rev 1/200)1	ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene \(\) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JAGNISZ ALEKSANDER 8.55AM MAY 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. MAY 17, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1[**X**M 2□ F 216-30-8543 75 UKRAINE Director Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ral', or iteme 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2X No Directo BALTIMORE MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 ORCHARD AVENUE U.S.A. 21225 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 MAINTENANCE DOMINO SUGAR CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) h and Mental ? PAWEL JAGNISZ ALEXANDRA POLIVKO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health airem 27 l REV. PHILIP JAGNISZ/ SON 329 ORCHARD AVENUE, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it eny injury or o once. N Burial 2 ☐ Cremation 3 ☐ Removal from State ST. ANDREW'S CEMETERY 5/18/06 BALTIMORE, MD. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HO 1901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEHYDRATION 1 WEEK /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine physicien end s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical as attending properties of the second IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, B Probably 4 □Unknown MELLITUS 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2V2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2√2 No Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by illed in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 19 2006 Lamorth RES 000 MAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRABHAKAR, 3001, SHANOVER STREET, BALTIMORE, MARYLING DR. MA MATHA 21225 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

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			Decedent's Name (First, Middle, L.)	ast)		Citino	ale or i	Jealii	2. Date of De	Rag. No	0.	3 Fine of Booth
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	Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last birtho	Mont	nder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bit	th	9 Bi	rtholace (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town o	r Location						10d. Inside City Limits
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ichae	death	by Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S.			ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No)-	14. Race - Am	erican Indian,
	or It	J. Y	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give			s 2XX No	Specify:	rican, etc.)		Black, Wh	
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<u>a</u> C	uld be Aental rked c	To B	Michael Kantorsk	i				Marie G	ornowit	z		
n 七〇ス5ドi Maryland 2121	2 should and Men is marke eumatic	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Addr	ess (Street a	ind Number or Run	al Route Numb	er, City	or Town, State,	Zip Code)
	C -= C4 -		Anna Kantorski	Wife				nue, Dun	dalk, M	aryl	and 212	222
altimore,	of H if Ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3		20b. Place of Di cemetery, of	sposition (Name of or other place	May	Date 23	20c. L	ocation - City or	Town, State
二量	Pages tment of tant: if It jury or o	١,	4 □Donation 5 □ Other (Spec	ify)	Oak Law	n Cem	etery	20		Dur	ndalk, M	Maryland
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	40240		230 Both Enter the disease of any	conne	lly	7110	Solle	rs Point	Road,	Dund	lalk,Mar	yland 21222
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<u>ita</u>	sician: The la certificete ha irector, page 2	a	25. Was case referred to medical	1				26. Place of Death	1 Yes	No No	1 Yes	2 □ No
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(\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	or Ati fler d diract n by	Certification:	3 Suicide 6 Could not t 4 Homicide determined	28e. Ptace of Injury building, etc. (5	- At home, farm, Specify)	street, fact	ory, office		28f. Location (S City or Tow	treet an	d Number or Ru	ural Route Number,
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	To the within 2 To the complete	Me	29b. Signature and title of certifier	A A		- 2	29c. License	number	- :	29d. Dat	e signed (Monta	h. Dav Year)
			· //	1/h			1)4	5475		51	19/01	
1	12		30. Name and address of person who	completed cause of death	h (Item 23a) (Tvo	e, Print)		11)			1110 4	
	0		DR. Mohamma	d RAHN	ama		10'7PG	anklin S	C. UO.R.F	de.	Ra Hi	mare, 472123
	Sta	,e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	M. B			1	-134	1,000	- VA
	Registr	ar	BERV 9 9 2006	FAR . O. L.	To Addition	S. Contraction						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year BLANCHE KAYE 16 cm 2006 MAY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ELLICOTT CITY HOWARD ELLICOTT CITY HEALTH & REHAB CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F 87 NY 054-10-6812 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ed other then "naturel", or Items 23a or 28a-f show event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No HOWARD COLUMBIA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 CEDAR LANE #372 21044 USA or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel', or teneny injury or other treumetic event, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: ģ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (9-12) College (1-4or 5+) **BOOKKEEPER** AMERICAN CUTLERY CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LANDAU HIRSCH HYMAN BERTHA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3331 N. CHATHAM ROAD #J - ELLICOTT CITY, MD 21042 DIANA SCHLOSSER / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State NEW MONTEFIORE CEM. 05/19/2006 PINELAWN, NY 4 □ Donation 5 □ Other (Specify) 21. Signature of 22. Name and Address of Facility SOL LEVINSON & BROS., INC. a 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or con is n resulting in death) ASPIRATION PNEUMONIA Physician DAYS /Medical Due to (or as a consequence of): Examiner TO THRIVE HICURE Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner ed by the attending physician and detached for use as the burial transit PEMENTIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autoosy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending Injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053150 NAY109 2006 9650 SANTIAGO ROAD 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) Shawnmala COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 2 2 2006 Registrar DHMH 17 Rev 1/2001

06-03348 Darryl Lang

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1-For State Amend Items#19a&20b perCFFfific855057421/06 CC Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day May 18, 2006 Medical Examiner 0045 hrs Everett 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death NA Johns Hopkins Hospital Baltimore 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Foreign 27.98.6475 Director 38 09.28.196 Country) MD 1 M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No items 23a or 28a-f show ust be notified at once. MD hours after death with the Maryland Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Marble Hall Road 4553 Funeral 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, must be Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 0. Black Widowed Divorced Yes, Give Yea Yes 2 No specify: Specify "natural", \$ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Elementary/Secondary (0-12) College (1-4 or 5+) t Pages 1 and 2 should be filed within 72 l-rment of Health and Mental Hygiene. rtant: If item 27 is marked other than "r-y or other traumatic event, the Medical E Complet Itimore, MD 21215-0036 ruck Driver urage Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Kaloh Williams Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route N ber, City or Town, State, Zip Code) 4553 Marble Hall Myy Myrtle Patricia Lang/wife alto. MD 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place 1 X Burial 2 Cremation 3 Removal from State Baltimore MD permit Page
Department of edav Donation 5 Other Specify. Gignature of Funeral Service Licenses Greene Puneral Services Road Baltimore MD 21212 Puneral Services 363 23a. Part I. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be execute and Physician/Medical UNPENDED AMENDED physician Division of Vital Records, P.O. Box 68760, attending phys for use as the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the att ector, page 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) æ examiner? Other 7 DOA this Nursing Home 5 Residence 6 Other 1 V Yes No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred Certification: May 17, 2006 1 Natural Subject was shot 2344 hrs n 24 hours after death ne Funeral Director: / pletely filled in by the fi Pendina Yes 2 V No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4553 Marble Hall Road, Baltimore, MD determined (Specify) Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only To the I 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 18, 2006 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month rar's Signature State 200 MENEN

Registrar

		ľ	For Stata Registrar	State	of Mary	land / Depa <i>Cei</i>	artmer <i>rtificat</i>				lental Hy	giene Reg. No	2 U	06	15953
	4 4		1. Decedent's Name (First, Middle, La	st)		-			7. 17.,17		2. Date of De			Year	3. Time of Death
	Physici /Medio		Anthony John Love	rde							MAY	19	-	606	0754 AM
	Examin		4a. Facility Name (If not institution, given		ımber)				Location	of Death	•		. County		
			Union Memorial Hosp		T			imore		0.411		Ŀ	Baltim		
	Funeral		5. Social Security Number 6. 9 217 64 3489	Sex 1☐M 2☐F	7. Age (In	yrs. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di January	rth ay Year 10	355	9. Birtho	place (State or Foreign ntry) More, Mary Land
	Director		Usual Residence of Decedent	X	J.L					1	January	1 15	,,,,	татти	ible, ralylaiti
	yland		10a. State 10b. County		10	c. City, Town or Lo	cation							1	0d. Inside City Limits
	a-f et	to	Maryland Baltimore			Baltimore (County	7							1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zi					_	itizen of W	Vhat Cour	ntry?
	23a	raf	5226 King Arthur Circ					237				USA			
	er de	Funeral	11. Marital Status	12. Was Dec	orces?	in U.S. 13. \	Was Dece f Yes, spe	edent of H ecify Cuba	ispanic O In, Mexica	rigin? (Spann) In, Puerto	ecify Yes or No Rican, etc.)	0-		e - Americ k, White,	can Indian, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, G Year or I			1 □ Yes	2∏ No	Specify	:			Specify	. Whi	te
Ş	thou stura		15. Decedent's E			16a. Dece	dent's Usu	al Occup	ation			16b. k	Cind of Bu		
215	hin 7.	Completed	(Specify only highest gr Elementary/Secondary (0-12)) (1-4or 5+)	(Give	kind of wo	ork done d use retired	<i>during</i> mo ()	st of work	ing				
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pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)							(First, Middle	, Maidei	n Sumam	(e)	
yla	Men Men Marke Marke	ဥ	John Loverde							læn I					
Mar	12 sh h and 7 ts m reum		19a. Informant's Name/Relationship	Type, Print)			•				ltimore,				(Code)
Baltimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or items 23a or 28a-f ehow or other traumatic event, the Markical Examinar must be multified at		20a. Method of Disposition		2	0b. Place of Dispo	* Contractor		UII C		Date Date				own, State
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들			4 Donation 5 Other (Speci 21. 96 pature of Funeral Service Lice			Metro Crem	A COLY I. Name a					Balt	imore	Mry	Land
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			23a. Part1. Enter the disease, or com	plications that	c trised the	death. Do not ent	er the mod	de of dyin	Poor!	cardiac	ore Mary	land irrest,	21236	-	Approximate
	Physician	k iii	Immediate Cause (Final	one cause on	each line.									1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)			nsequence of):	1017							-	3 WEEKS
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387		dicai	•	_ d											
9 X	that the death certifi ed by the attending I detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	itcome of pi	regnancy							23d Date	e of delive	207
Вох	death a atter	ciar	in the past 12 months?	4□Preg	nant at time]Ectopic p] Other (s _i						Mon		Day Year
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ord	w require been si should t										10	Yes 2	□No	3 Prob	ably 4 □Unknown
ec	lawr es be	Completed									24a. Was		24b. W	Vere auto	psy findings available mpletion of cause of
<u>~</u>	⊕ CL	ပ္ပ									perfo 1 ☐ Yes	2 No	d	leath?	
/ita	sician: The law scertificete hes t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	,			101		e of Death	(Check only	one)			
of	Physician: this certifice ral director, I	2	1 Yes 2 No	11		2 ER/Outpatien			4 🗆 14		me 5 ☐ Resi				v)
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Θ	after after Dire	erti	4 Homicide	build	ting, etc. (S	pecify)		,,			City or To	wn, State	э)		
	spita hours inera y fille		29a. Certifier 1 Certifying P	ysician: To th	e best of my	y knowledge, death	occurred	at the tim	ne, date a	nd place,	and due to the	cause(s) and mar	nner as st	ated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Exa	miner: On the t	nasis of exa	mination and/or inv	vestigation	n, in my og	oinion, de	ath occurr	ed at the time,	date an	d place, a	ind due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier				29	c. License	e number			29d. Da	te signed	(Month,	Day, Year)
			b chaused bein	10			A	T243	3946			MA	4 19	1 20	06
	12		30. Name and address of person who												
			31. Date filed (Month, Day, Year)			M MOINN	EMUR	IAL 1	HOSPI	TAL,	WD				
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			1 - For State Registrar	State of M	aryland / Depa		Health and	Mental Hygi	ene g. No. 2006	15954
	Dhysisi		Decedent's Name (First, Middle, La	ast)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		PHILIP	J.	LANCIO	NE, SR.		MAY	19, 2006	6:35 A.M
1	Examir		4a. Facility Name (If not institution, gir	ve street and number,		4b. City, Town, o	or Location of Deat	ח	4c. County of Death	
			HARBORSIDE HEAL	THCARE		BALC	TIMORE CI	TY	N/A	
	Funeral			Sex 7.A 15√2 M 2 □ F	ge (In yrs. last birthday) Om Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 6/17/19	Year) 9. Birthi	place (State or Foreign ntry)
	Director		717-09-0174 Usual Residence of Decedent	A	87 Yrs.			0/17/19	10 MAR	/LAND
	ylanc		10a. State 10b. County		10c. City, Town or Lo	ocation				Od. Inside City Limits
	e Mar	ctor	MD N/A		BALTIMO	ORE CITY				1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	ath w	62	1660 NORTHBOUR				239		USA	
	teme	Funerai	11. Marital Status	12. Was Decedent Amed Forces	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐		1 ☐ Yes 2 ☑ No	Specify:		Specify:	WHITE
21215-0036	within 72 hours after death with the Maryland ane. then "naturel", or Items 23e or 28e-f ehow the Mudical Exh. ulter Lual be notified at	Completed by	15. Decedent's E	Year or Dates:	16a, Dece	dent's Usual Occur	pation	1	6b. Kind of Business/In	
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Jar	s 1 and 2 should f Health and Mer ltem 27 lu marke other traumatic	1 1	19a. Informant's Name/Relationship						City or Town, State, Zip	Code)
	s 1 and if Health Item 27 other tr		ROBERT M. LANCING 20a. Method of Disposition	OE/SON	20b. Place of Dispo	+ DOXBURY	ROAD T	OWSON, MD	21286 0c. Location - City or To	our State
Baltimore,	00-		1 ☐ Burial 2 🖾 Cremation 3 [cemetery, cre	matory or other pla	· .			
Him	글 된 원 글 .		4 Donation 5 Other (Special Signature of Funeral Service Lice		METRO CRI	EMATORY, 2. Name and Addre			ATONSVILLE,	
Ba	Depa Impo eny l		21. Signature of Puneral Service Lice	risee				LVD. 10WS	N FUNERAL I ON, MD 212	S (2-12)
	_		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause						Approximate
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6876	physic physic the b	dicai		d						
9 X	ding ding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				004 Day 444	
Вох	leath certifica ettending ph d for use as th	cian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	y		23d. Date of deliver	Day Year
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٦.	es that igned b be deta	by Pt	Part II. Other significant conditions	contributing to death I	out not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
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Be	The lav	E						autopsy	ed? death?	mpletion of cause of
		0	25. Was case referred to medical				26. Place of Dea	th (Check only one	-	24.140
*	d is	ToB	examiner? 1 🗆 Yes 2 🖟 No	Hospital: 1 _ Inpati	ent 2 ER/Outpatier	nt 3 DOA Oth	ner: 4 Nursing H	ome 5 Residen	ice 6 Other (Specif	y)
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ury 28b. Time o	f 28c. Injur Wor	y at	28d. Describe how	v injury occurred	
Sio	Attending in death.	catio	2 ☐ Accident investigation	-	54		Yes 2 □No			
Division	pr Att	Certification:	3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined	289. Place of in	jury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	I Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 124 Certifying P	hyeicien: To the best	of my knowledge dass	b occurred at the sta	me date and sizes	and dup to the	100(a) and a	
	24 hc 24 hc Fun etely	Medical	(Check only one) 2 Medical Exa	miner: On the basis of and manner st	of examination and/or in	vestigation, in my o	ppinion, death occu	rred at the time, dat	use(s) and manner as s e and place, and due to	the cause(s)
	Fo the Mithin Fo the	Me	29b. Signature and title of certifier	1.01	'era eur	29c. Licens	se number / /	/ 29	d. Date signed (Month,	Day, Year)
			duest	, my		D	30661	1	lay 19th	2006
1	X		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print SIR	EESH TRI	HRAVENI		
1)			3601 doch Re	even B	Wa Bo	Mi mo	u / med	NX) (
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32 Regist	rar's Signature	A STATE OF THE STA				

	4	Plea	ise T	ype or Pri State of M		nd / Depa	artmo	ent of H	lealth and		•		•	
	_	Registrar				<u>Ce</u>	rtific	ate of	Death			Reg. N	No. 000	
Physician /Medical		1. Decedent's Name (First, Midd Frank		holm Lym	an						Date of I Month May		2006 Year	9:30 A M
Examiner	4	4a. Facility Name (If not institution	-						Location of Dea	th		4	c. County of Deat	h
		Renaissance Gar					_		Spring				Prince G	
Funeral Director		5. Social Security Number 577–14–6108	6. Sex	7. A		last birthday) 5 Yrs.	If Un Mont	der 1 Year ns Days	tf Under 24 Hrs Hours Min	-	Date of I (Month, Pt.	Оау. Үва	17 1 Co	hplace (State or Foreig untry) nington, D.(
naturel', or iteme 23e or 28e-f ehow alfal Exporter cust be notified at eted by Funeral Director	-	Usual Residence of Decedent 10a. State 10b. County			10c. Ci	ty, Town or Lo	ocation							10d. tnside City Limits
8a-f-el			e G	eorge's		Silve						·		1 ☐ Yes 2 ☑ No
23e or 2 lathens al Dire		10e. Street and Number 3160 Gracefiel	d R	oad			10f.	Zip Code 2	20904				Citizen of What Co ted State	•
Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "naturel; or Iteme 23a or 28a-f ehow important: if Item 27 ie marked other then "naturel; or Iteme 23a or 28a-f ehow interpretation of the marked of the mar		11. Marital Status 1	ried	12. Was Decedent Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	? No			cedent of H pecify Cuba 280 No	ispanic Origin? (! an, Mexican, Pue Specity:	Specify rto Rica	Yes or i	No-	14. Race - Ame Black, White Specify: W	
natur dead		15. Deceder (Specify only highe				16a. Dece (Give	dent's U	sual Occup work done	ation during most of wo	orking		16b.	Kind of Business/	Industry
then the		Elementary/Secondary (0-12)		College (1-4or	5+)	1			n Directo			Fe	deral Go	vernment
Tie marked other then "naturel", creumatic event, the Mudical Executed manufactured by		17. Father's Name (<i>First, Middl</i> e, David Hinckley		man, II					18. Mother's Na Josepl					v1 , , , ,
- E		19a. Informant's Name/Relation					_						y or Town, State, 2	
m 27 her tr	-	Frank T. Lyman,	Jr	./Son	20h I				rtn way,	Date	Lumb		Maryland	
Important: If Item 27 is eny injury or other tre <u>once.</u>		20a. Method of Disposition 1 □ Buriat 2 ☒ Cremation 4 □ Donation 5 □ Other (5	Specify)		Moi	Place of Dispo cemetery, cre ntgome: matori	matory of Cy .um,	Inc.	Ma:	y 2:		Ве	thesda,	Maryland
eny in		21. Signature of Funeral Service	License	9	M001	.98 Ro	beri 57 W:	A. I iscons	sin Ave.,	Fu Be	nera thes	1 Ho	me/ ^{Bethe} Cha MD 20814	sda-Chevy se, Inc. -3501
vysicien and Medical aminer puriality of particular and aminer provided the provided that the provided the provided that		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as	COVAS a consec a consec	quence of):	Acc	ident						Interval Between Onset and Death 3 days
ed by the attending physicached for use as the		tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2:	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 Feta	al death 3		pregnancy (specify)				-	23d. Date of deli Month	very Day Year
signed b		Part II. Other significant conditi	ons con	tributing to death	out not res	sulting in the u	nderlyin	g cause giv	en in Part I.			tobacco		the cause of death?
page 2 should be d											24a. Wa	as an lopsy formed?	24b. Were au prior to death?	topsy findings available completion of cause of
rector, pag		25. Was case referred to medical	1						26. Place of De	ath (C	1 Yes		4o 1∐Yes	2□ No
director,	1	exeminer? 1 ☐ Yes 2 ☒ No	-	ospital: 1 ☐ Inpati	ent 2	ER/Outpatier	nt 3□	DOA Oth	or				6 X Other (Spec	Assisted
Atter this of funeral direction; To		27. Manner of Death 1 ⊠Natural 5 □ Pendi	ng gation	28a. Date of Inj (Month, Da	ury	28b. Time o Injury		28c. Injun Worl					ury occurred	Assisted Living
within 24 hours after death. To the Funerel Director: Alter this completely filled in by the funeral di Medical Certification; To		3 Suicide 6 Could 4 Homicide deterr		28e. Ptace of tr building, e	jury - At h tc. <i>(Speci</i>	ome, farm, sti	reet, fac	tory, office		281.	Location City or T	(Street own, Sta	and Number or Ru ate)	ral Route Number,
thin 24 hour thin 24 hour the Funer mpletely till		29a. Certifier 11 Certifyi (Check only one) 2 Medical	ng Phys Examir	ician: To the besi ter: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurr vestigat	ed at the tin ion, in my o	ne, date and plac pinion, death occ	e, and urred a	due to th t the time	e cause e, date a	(s) and manner as nd place, and due	stated. to the cause(s)
		29b. Signature and title of certific	W	Messite	HE)		29c. Licenso	o number 0043375				y 18, 200	
1704		30. Name and adoless of person Karen W. Merrit		M.D. 3110) Gra	cefiel	d Ro	oad, S	Silver S _l	pri	ng, I	Mary	land 2090	04
State Registrar		31. Date filed (Month, Day, Year MAY 2 2 2	006	32. Regist	rar's Sign	ature	Se. A							

DHMH 17 Rev 1/2001

State Registrar

			For State Registrar	State	of Ma	ryland / I		artment of F rtificate of	lealth and N Death		ene g. No. 0	16	15956
	(i)	4.0	1. Decedent's Name (First, Middle, La	st)						2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic			ľ	Mary	Mildr	ed	Martino		May 18,		Teal	12:05 P M
	Examin		4a. Facility Name (If not institution, give	e street and n	umber)			4b. City, Town, o	r Location of Death		4c. Count	y of Death	
		des 🛌	8003 Lansdale	Road				Colga	ate		Bal	timor	e Co.
	Funeral			Sex	7. Age	(In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign ntry)
	Director		215-30-0822	1 □ M 2 🙀 F	•	74	Yrs.	Wonth's Days	Tiodis Witt.	Aug. 31			ryland
	2		Usual Residence of Decedent			10-00-7							
	show	_	10a. State 10b. County			10c. City, Tow	m or Lo	ocation					10d. Inside City Limits 1 ☐ Yes 2☐No
	Ba-f.	cto		altimor	e				Colo				
	or 2	Director	10e. Street and Number					10f. Zip Code	100	10	g. Citizen of	What Coul	ntry?
	23a	8	8003 Lansdale						21224		Unite		
٥	s filed within 72 hours after death with the Maryland if Hygiene. other then "natural", or flems 23a or 28a-f show other then "natural", or flems 23a or 28a-f show ont. the Madical Examinar man be modified at	/ Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was De Armed F 1 Tes If Yes, G	orces? 2 ⊡ N			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecfy Yes or No- Rican, etc.)		ck, White,	can Indian, etc.
9500-61212	ural',	d by	3 √Widowed 4 □ Divorced	Year or	Dates:							Wh	nite
ה ה	72 h	Completed	15. Decedent's E (Specify only highest gr)	16a	. Dece	dent's Usual Occup	ation during most of work d)	ang	6b. Kind of E	Business/In	dustry
2	ne. hen	ш	Elementary/Secondary (0-12)	College	(1-4or 5-	+)			D)				_
N	lled v tygie her t		12 Years 17. Father's Name (First, Middle, Las.	/ 1			S	ecretary	18 Mother's Nam	e (First, Middle, N		erica	1
בב	e d at b	Be	_	7								110)	
Maryland	should be ind Menta i marked umatic ev	٩	Frank Henry	(Trues Dries)		1.00	n Marilli	an Address (Ctront	and Number or Rui	Saunders		Ctata 7ia	Cadal
<u>8</u>	S se se		19a. Informant's Name/Relationship Mrs. Lois Krepner		tar'			•	Road Ba				21224
ď.	is 1 and 2 should of Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	(Daugi	ICCI,			sition (Name of			20c. Location		
0	if it of h		1 ☑ Burial 2 ☐ Cremation 3 [State	cemete	ry, crei	matory or other place	ce)				
	tmer tant		4 Donation 5 Other (Special			Garde			Cem. 5/2:	2/2006	Balt:	lmore	, Maryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any njury or ot once.		21. Sig. ature of Funeral Service Lin	nsee C	L	0	D.		Funeral I				
de la			23a, Port . Enter the disease, or con shock, or heart failure. List only	nplications that	caused	the death. Do	not en	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final	one cause on	O. F	INCE	R	OF T	HE LU	ING			Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	o (or as a	consequence	of):						2 montus
	Examiner				a	OPI							years
120	# 100 m	Je.	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	o (or as a	consequence	of):						-0
	uted d ansit	Examiner	Cause (Disease or injury	C									
'n	exec In an ial-tr	Exa	resulting in death) Last	Due to	(or as a	consequence	of):						
8/60	icate be executed physician and s the burial-transit	dlcal	(d									
0	g phy as th	ed											
ROX	eath certific attending p I for use as	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			2 7	Testania programa			23d. Da	ate of deliv	ery
ă	death e atte d for	Cla	in the past 12 months?	4⊟Pre	nant at	2 ∏Fetal deatl time of death		<pre>LEctopic pregnancy Other (specify)</pre>	y 		M	onth	Day Year
J.	that the de led by the a detached f	hys	9 Unknown	9□ Unk	nown		-		_				
Division of Vital Records, P	98	d by Physician/Me	Part II. Other significant conditions					nderlying cause giv G ト ST	ven in Part I.	23e. Did tob		tribute to t	he cause of death?
Ö	w require been si should l	lete	ABDOMIN	LAI	Aa	RTIC	A	NEURY	SM	24a. Was ar	24b	Were auto	opsy findings available
Ĕ	he law s has	Completed	7,5000,011	, ,,,	, , ,	, , , , ,	- ' '			autops: perform	/	prior to co death?	empletion of cause of
7	n: Ti ficate or. pa		OF Man case referred to medical								No	1 ☐ Yes	2 □ No
Ĭ	sicia certi recto	Be c	25. Was case referred to medical examiner? 1 Yes No	Hospital:	7 Innatia	- a [[EB/O		Oth		th (Check only one		(0	
ō	Phys rat d	- T	27. Manner of Death	28a. Date	Inpatie	y 28b.	Time o	11 3 DOA	4 Nursing H	ome 5 Reside 28d. Describe ho			у)
5	ding h. After fune	tlon	Natural 5 Pending	(Mo	nth, Day	Year)	Injury	Wor	rk? Yes 2 □No		,		
2	deat deat ctor: y the	flca	3 ☐ Suicide 6 ☐ Could not I	De 200 Blac	ce of Iniu	ırv - At home, f	arm, st	reet, factory, office		28f. Location (Str	eet and Num	ber or Rura	ai Route Number.
<u>></u>	after Dire	Certification:	4 ☐ Homicide determined	buif	ding, etc	. (Specify)	,	001, 100101, 011100		City or Town			
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledical C	29a. Certifier Certifying P	hysician: To ti	ne best of	f my knowledg	e, deat	h occurred at the tir	me, date and place, opinion, death occur	and due to the ca	use(s) and m	anner as s	itated.
	the h iin 24 the F iplete	led	one)	and ma	nner sta	ted.		· · · · · · · · · · · · · · · · · · ·					
	To T Com	Σ	29b. Signature and little of certifier	A Di adames	lia	fater)	MS	29c. Licens	e number) 29	d. Date signe	ed (Month,	Day, Year)
			try ka	. J. (J. (J. ()		3	_	D	1つ 462		2/1	0/2	006
1	OT		30. Name and address of person who	completed ca			(Туре,	Print) 0 E. 3311	15462 5+#64	O BALT	70. H	D. 3	11218
6.9	Sta		31. Date filed (Month, Day, Year) MAY 2, 2, 2		15/21	r's Signature	An	acke	2.000				
Y A	Registi	ar	WAYZZZ	UUU I ATA	THE ASSET	1 16	167						

		Į.	State of Maryland / State of Maryland / Registrar	Department of He			ZUUb	15957
	1	e e	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of D		Reg. I	No.	3. Time of Death
	Physicia		William P. Mart	in			Day Year	2/00 AU
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	ocation of Death		4c. County of Death	
* 42		٠.	5927 Charles Stree	t Balt	imore	MD	Balt	imore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea March 18,	9. Birth	place (State or Foreign
	Director		3/9-/2-031/ 32	Yrs.		March 18,	1954 Wash	nington D.C.
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
	Maryl -faho ieda	tor	Maryland Baltimore Gwynn	0ak				1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number	10f. Zip Code		10g. (Citizen of What Cou	untry?
	h with		927 Charles Street	21207	7		USA	
	ams ams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	s after or It	by Fu	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No		Specify:		Specify: Wh	
Ö	filed within 72 hours after death with the Maryland Hygiena. sther than "natural", or Itams 23c or 28a-f ahow snt, the Medical Evand set must be rediffed at		3 Widowed 4 Divorced Year or Dates:	6a. Decedent's Usual Occupat	ion	16h	Kind of Business/I	ndustry
21215-0036	in 72 n "na hedic	Completed	(Specify only highest grade completed)	(Give kind of work done du life. DO NOT use retired)	irina most of work	ing	. Italia or basilies wit	oustry
212	d with giena. r thai	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Social Worker		н	ealth Car	re .
5	a file al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Maid	len Sumame)	
<u>la</u>	Menta	To	Jerome Martin		Kathle	en Hurley		
Maryland	gas 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiena. If item 27 Is marked other than "natural", or Itams 23c or 28a-1 ahow or other traumatic event, the Medical Esans estimate to colline at			9b. Mailing Address (Street ar P. O. Box 480)				p Code)
	f and Health om 27 thar t			e of Disposition (Name of			Location - City or T	Town State
Baltimore,	permit. Pagas 1 a Department of Hea Important: If item any injury or otha once.		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ceme	etery, crematory or other place,	5/23/	V =	_	
를	permit. Page Department of Important: If any injury or once.		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	o Crematory 22. Name and Address				, Maryland
Ba	permi Depar Impor any ir		I ma della	Funeral Ho 1630 Edmon	me of Ca	tonsville	Inc.	WD 21220
			23a. Part . Enter the disease, or complications that caused the death. D				usville,	Approximate Interval Between
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	itoneal L	-10050	ircoma		Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a con-equence)		1 1 30			
	Examiner		Sequentially list conditions b. Venous	thromb	2120			
	Pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):				
	and and I-tran	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence	ce of):				
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al E						
687	ficate p phys	edical	d.	nm.c.				
Вох	death certifics attending ph d for use as t	n/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea				23d. Date of deliv	/ery
Ö	ne death the atte	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown				Month	Day Year
P.O.	that the de ed by the a detached	Physician/Me	9 Unknown					
Ś	w requires tha been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause giver	n in Part I.			the cause of death?
orc	requi	eted				- A MANAGEMENT		96
Sec.	elaw hasta je 2 s	Completed				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
a						1 Yes 2 d		2 No
₹	Physician: r this certifica ral director, a	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 □ EP/	Outpatient 3 DOA Other		me 5 Pesidence	6 DOther (Cree	36.71
o	g Phys er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28t	b. Time of 28c. Injury a	at	28d. Describe how in		197
<u>o</u>	ttending l death. stor: After / the funer	atlo	1 🗹 Natural 5 🗆 Pending (Month, Day Year) 2 🗆 Accident investigation	Injury Work? M 1 ☐ Ye	es 2 □ No			
Division of Vital Record	l or Attendafter death Diractor:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or Rur	al Route Number,
	ital o							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) 1 ✓ ertifying Physicien: To the best of my knowled 2 ☐ Medicel Exeminer: On the basis of examination and manner stated.	dge, death occurred at the time and/or investigation, in my opi	e, date and place, nion, death occurr	and due to the cause ed at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
	To the Mithin To the	Me	29b. Signatur and title of a rifler	29c. License			Date signed (Month,	
}			Mulus	D53	7916	5	119/20	206
. 7			30. Name and address of person who completed cause of death (Item 23.	a) (Type, Print)		5 Ste200	<u> </u>	
1	/		Franz Sewchandi	MD 700 G	eipe Rd	Ste 200	Catons	rille, MD
	Sta Registr		31. Date filed (MMH) (Pay 2) ear) 2006 32. Registrar's Signature	Speciel .				
	, region			77				

06-03324

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Please Type or Print in Black Indelible Ink Rudolph Matthews State of Maryland / Department of Health and Mental Hygiene 1- For State Amend Item# 20b per FH C855 22 606t/CC Reg No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 17, 2006 **Medical Examiner** Rudolph Matthews 0129 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital **Baltimore Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY) 9. Birthplace (State or Foreign Days Director 215.92.3787 Months Hours 27 1978 1 M 2 F 27 Country) MD Usual Residence of Decedent 10a. State 10b County à 10c. City, Town or Location 10d. Inside City Limits NIA Baltimore Mb Yes 2 No hours after death with the Maryland Director 23a or 28a-f notified at or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4103 Kinsway 21206 USA Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes Specify: Black Widowed Divorced 1 Yes 2 No specify: ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 item 27 is marked other than " traumatic event, the Medical Baltimore, MD 21215-0036 Clistomer Service Associate arnde *ears* t Pages 1 and 2 should be filed withi timent of Health and Mental Hygiene. rrant: If item 27 is marked other th or other traumatic event, the Med Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname Rudolph Matthews Be Alma Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Matthews/ 2901 Belair Road Baltimore MD 21047 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore MD Greenmount Chematon 4 Donation 5 Other Specify. 22. Name and Address of acility
Vaughn ("Greene Funeral Services
Vaughn ("Greene Funeral Services
AD 21212 Signature of Funeral Service Licensee M01363 Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line /Medical Between Onset and Death Cardiac Arrththmia Immediate Cause (Final disease €xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and ician/Medical X UNPENDED AMENDED 23a, 27 per me g858 8-28-06 vt burial Division of Vital Records, P.O. Box 68760, tending phys 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? this certificate ✓ Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other Nursing Home 5 DOA Residence 6 Other 1 🗸 Yes After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural within 24 hours after death.

To the Funeral Director:
completely filled in by the f 5 Pending 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 17, 2006 ress of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registra DHMH 17 Rev 1/2001

OCME 2006

State

31. Date filed Worth Day, Year 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** May™15, Evelyn Martha McKimmy Year 2:05 AM M **2**®06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Frederick Examiner 4b. City, Town, or Location of Death Frederick 8803 Yellow Springs Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec. | 14, 1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 27 F 212-20-0910 84 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28e-1 show 10d. Inside City Limits event, the Medical Examiner must be notified at Maryland Frederick Frederick 1 ☐ Yes Ž ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 8803 Yellow Springs Road 21702 U.S.A. 'natural', or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. nnt: If Item 27 Ie marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: þ 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Greenberry Poole Ella Murray Miles ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mrs. Carol M. Heffner, daughter 8803 Yellow Springs Rd., Frederick, MD 21702 other 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery May 18, 2006 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Reeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 929 V9C **Physician** 10 100 /Medical Examiner Recur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Multinadular gotter 1 ☐ Yes 2 No 3 Probably 4 Unknown Swallowing Disorder 24a. Was an 24b. Were aulopsy findings available prior to completion of cause of death? autopsy perform certificate 2 X No 1 Yes 2 No 1 Yes or Attending Physicien: after death.

Director: After this certific 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21944 May 15, 2006 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 21707 #204 S. BVE Grissom 147 James TANEY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. of Maryland / Department of Health and ntal Hygiene For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 900 izabeth Won MV 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Howard Columbia If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Jan 27, Director 86 1920 Wisconsin 392-18-9870 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. I other then "natural", or Items 23a or 28e-f ehow ivent, the Madical Examinar must be rutified al 1 ☐ Yes 2 ☑ No Completed by Funeral Director MD Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3004 N. Ridge Road USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2 Housewife Own Home ulth and Mental Hygid 27 is marked other r treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Anderson 2 Edwin Davey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: if Item 27 is any injury or other tree once. Barbara Marks/daughter 8566 Horseshoe Rd. Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euroral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 oude 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** ntractania disease or condition resulting in death) days /Medical Due to (or as a consequence of) Examiner Cerebro misch Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐ Pregnant at time of death 5 Other (specify) ete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 20 1 ☐ Yes Completed neumo na 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a Was an autopsy 200 No this certificete 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 TYes 2 No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ÷ 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 86 Steven e 61 32. Registrar's Signature 31. Date filed (Month, Day, Year) State COMPL Registrar 2 2006

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s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at	1	20a. Method of Disposition	ivais/ wile	20b. Place of	Disposition (Name of		Date 20	C. Location - City	or Town, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mentat Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinatings to untilised at once.		21. Signativa of Fundal Served Licens	www	I N	2. Name and Addres	liedefel	d Funeral	Home, Inc	
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215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23e or 28e-f show important: If item 27 ie marked other than "natural", or items 28e-f show any injury or other traumatic event, I're Madical Examiner must be notified at ance.	ted by Funeral Director	10e. Street and Number 709 Maiden Cho 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced (Specific only bioths	12. Was Decedent Amed Forces' ried 1 □ Yes 2 🔀	No	16a. Deced	Vas Deceder i Yes, specify Yes 25	229 It of Hispanic Cuban, Me	ecify:	Specify Yes or No to Rican, etc.)	USA 14.	Race - Americ Black, White, pecify: Whi	an Indian, atc.
2	should be filed within 7 and Mental Hygiene. marked other than "r imatic event, Ire Mad	Be Completed	Elementary/Secondary (0-12) unk 17. Father's Name (First, Middle,	College (1-4or unk	5+)	life. L	kind of work OO NOT use			me (First, Middle,	Maiden Su	mame)	unk
e, Maryland	ges 1 and 2 should be f of Health and Mental F If itam 27 te marked of or other traumatic eve	인	Edward Alford 19a. Informant's Name/Relations Charlestown Nu 20a. Method of Disposition		20b. Plac	709 M	aiden	Choic	umber or R	et Addisc ural Route Numbe e Catons Date	or, City or To Ville		229
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 Burial 2 Cremation 4 Donation 5 Other (5 21. Signature of Funeral Service Ronald	Decity)	cem	S1		Address of F	y Boar	d 655 W.			
8760,	Antician and hysician and hysician and hysician and the burial-transit	Ical Examiner	23a. Part1. Enter the diseas, o	b	a consequer a consequer	Do not enter Conce of):	altimo	11.11.11.11			rest,		Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed the seen signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic preg Other (spec				23d.	Date of delive	ry Day Year
	requires that leen signed b hould be deta	by	Part II. Other significant conditi	ons contributing to death t	out not resultir	ng in the un	derlying cau	se given in F	Part I.		obacco use		e cause of death?
of Vital Records,	ician: The law certificate has b rector, page 2 s	Be Completed	25. Was case referred to medica examiner?	ı =				26	Place of De	24a. Was autop perfor 1 Yes	sy med? 2 DyNo	prior to con death?	osy findings available appletion of cause of
Division of V	Attending Phyer death. actor: After this by the funeral di	Certification: To B	27. Manner of Death Natural 5 Pendia 2 Accident Investi 3 Suicide 6 Could 4 Homicide	28a. Date of Inju (Month, Da gation not be	y Year)	Bb. Time of Injury	28c	Injury at Work? 1 Yes		28d. Describe h	ow injury od	ccurred	
Ō	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	edical Cert	29a. Certifier Certifyin	ng Physician: To the best Examîner: On the basis of and manner st	of my knowle	odge, death and/or inv	occurred at estigation, in	the time, da	te and place, death occu	e, and due to the corred at the time, or	ause(s) and	d manner as sta	ated. the cause(s)
)	To the within To the comple	Med	29b. Signature and title of certifie	mo			5	icense num	f47		May	gned (Month, I	,
			30. Name and address of person	who completed cause of a	Mary	u C	Print)	Lan	((atonsu	V.		
	Sta Registr		31. Date filed (Month, Day, Year,	32. Regist	ar's Signature								

State of Maryland / Department of Health and Mental Hygiene) 5964 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Magruder 19 3066 Eugene
4a. Facility Name (If not institution, give street and number) 4.0 3 AM mai /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore C If Under 1 Year | If Under 24 Hrs. | 8. E Months Days Hours Min. | Hopkins Hospital TheJohns 141 8. Date of Birth (Month, Day, Social Security Number 6. Sex 1 X M 2 ☐ F last birthday) 9. Birthplace (State or Foreign **Funeral** Year) Yrs 212 14 9825 Usual Residence of Decedent 5,1910 MARYLAND Director FEB. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE MD. N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Amed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-1X) Yes 2 \(\text{No} \) No 12/5/42

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Yes, Specify Yes or No-1X Yes 2 \(\text{No} \) No Specify. iteme 23a or 1616 N. BROADWAY USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 þ Specify: BLACK 3 ☐ ₩idowed 4 ☐ Divorced "naturai". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Importent: if Item 27 ie marked other then "na any njury or other traumatic event. Ite Madic 2005. EDGEWOOD ARSONAL Elementary/Secondary (0-12) College (1-4or 5+) 12TH SUPPLIES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORENCE BALLARD UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDDISTER CHAPPLE SR. (son) 1616 N. BROADWAY BALTIMORE, MD. 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition GARRISON FOREST VET.CEM. □ Surial 2 □ Cremation 3 □ Removal from State 8WINGS MILLS: MB: 4 Ø onation 5 ☐ Other (Specify) 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON STREET BALTO, 21 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BALTO, MD. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia mfaret **Physician** days /Medical Examiner pulle arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit asperation the attending physician and Due to (or as a consequence of) by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2X No 1 Yes 2 No 1 Tyes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one examiner?

1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural s after dee. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) MD, PLD May Estaten two thousands ix 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street Baltymore Maryland 31. Date filed (Month, Day, Year)
MAY 2 32. Régistrar's Signature State 2 2006 Registrar

			1 - For State Registrar	State of M	Marylar		artmen <i>rtificat</i>			and M		giene2 (06	15	965
	1. Decedent's Name (First, Middle, Last)								2. Date of Dea			3. Time of Death			
	Physicia /Medic		A	11en Johi	nson_N	Tylen						14, 20		5:34	P M
	Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	of Death		4c. Coun	ty of Dear	th	
			17508 Princ					4.4	01ne					gomery	
	Funeral		5. Social Security Number 6. Se	9X XDM 2□F		last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day	(, Year)	9. Birt	thplace (State ountry)	or Foreign
	Director		579-50-3401 Usual Residence of Decedent		66						Sept.	10, 1939	wa wa	shingt	on, D.
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits
	Mar	tor	Maryland Mont	gomery					01ney	7				1 □ Ye	s 2∏No
	or 28	Director	10e. Street and Number	<u> </u>			10f. Zip	Code				10g. Citizen o	f What Co	ountry?	
	23a	rai	17508 Princ	e David I	rive				20832	2		Ur	nited	State	S
	tems from	Funerai	11. Marital Status	 Was Decede Amed Force 	s?	.S. 13.	Was Deced If Yes, spec	dent of His	spanic Orig n, Mexican	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	14. Ra Bl	ace - Ame ack, Whit	erican Indian, e, etc.	
2	s afte	by Fi	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 (If Yes, Give Year or Date:		1961	1 🗆 Yes	2 🔀 No	Specify:			Spec	ify:		
3	be tiled within 72 hours after death with the Maryland all hygiene. did hygiene. did hygiene. did ther then "natural", or items 23a or 28s-f ehow event, the Medical Exacidrar most be notified at		15. Decedent's Ed		s. 1997 .	16a. Dece	dent's Usua	al Occupa	tion			16b. Kind of	Business	White	
2	n "na	Completed	(Specify only highest gra-	de completed)		(Give	kind of wo DO NOT us	rk done di	uring most	of worki	ng			tate	
7	d with	mo:	Elementary/Secondary (0-12)	College (1-4d	n 5+)	Owr	er/Op	erat	or		İ	Tit1	Le Se	rvice	
2	othe vent,	BeC	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,	Maiden Suma	ime)		
<u>ā</u>	Venta Venta rked rice	ToE	Edward W. Nylen						Alio	се В	. Jackso	on			
<u>8</u>	and I	•	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	r or Aura	l Route Number	r, City or Tow	n, State, 2	Zip Code)	
١, ١	and sealth		Sandra A. Nylen	/ Wife					avid		ve, 01ne				32
ב כ	of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Sta		emetery, crea	natory or o	ne of ther place)	May	21.	20c. Location	- City or	Town, State	
	Pag ment tant: jury c		4 Donation 5 Other (Specify)	1 1	dontgom Cremato	rium			2006		Bethe	esda,	Mary1	and
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene I have a second to the Theory of Hygiene I have been the Hygiene. Department of Hygiene I have been the Medical Examination of Hygiene.		21. Signature of Funeral Service Licen	1		22	2. Name an	d Addres	s of Facility	Robe	ert A. 1 00 West nd 20850	Pumphre Montec	y Fu	ıneral Avenu	Home/
	48204		23a Barti Enter the disease or come		01420	h Do not ont	Rocky	ville	, Mar	cy1ai	nd 20850	0-2805			
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Dea										etween		
			disease or condition resulting in death) Hepatocellular Carcinoma Due to (or as a consequence of):												
	Examiner		Due to (or as a consequence of).												
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c												
,007	e exe	Ë	resulting in death) Last Due to (or as a consequence of):												
0/0	icate be executed physicien and s the burial-transit	dical		d											
Š	fing p	0	IF FEMALE:	20- 11				1							-
ממ	attend tor us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							23d. Date o			ivery Day	Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant 9⊡Unknown		eath 5	Other (sp	еспу)							
ŗ	w requires thet the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob							pacco use contribute to the cause of death?					
Ö.C.	urres sign id be	d by								1 Yes 2 No 3 Probably 4 Munknown					
3	w req	iete								24a. Was an 24b. Were autopsy findi				available	
1 6 9 N Q							med?	prior to completion of cause of death?							
2	an: T tiftcat tor, pi	a	25. Was case referred to medical						26 Place	of Death	(Check only on		1 L Yes	2 No	
5	Physician: r this certition ral director,	To B	examiner? 1 ☐ Yes 21XI No	Hospital:	itient 2	ER/Outpatier	nt 3 DC	A Othe	r-		Home 5 M Residence 6 □Other (Specify)				
5	ig Ph ter th veral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at						28d. Describe how injury occurred						
5	endin ath. or: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		, July	injury	М		es 2 🗆 N	No					
2	r Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ב	ital o	. 1													
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certiticate he completely tilled in by the tuneral director, page	edical	29a. Certifier 1 X Certifying Phy (Check only 2 ☐ Medical Exam one)	i ner : On the basis	of examina	wledge, death tion and/or in	occurred vestigation,	at the time in my opi	e, date and inion, deat	d place, a h occurre	and due to the ca ed at the time, d	ause(s) and m ate and place	nanner as , and due	stated. to the cause	s)
	o the ithin 2 o the ample	Med	29b. Signature and title of certifier	and manner	aidied.		290	License	number		2	9d. Date sign	ed (Monti	n. Dav. Year)	
	F 3 F 8	1	LKN			CIM									
	X		30. Name and address of persol who d	completed cause of	death (Item	n 23a) (Type	Print)	D35	033			May	15,	2006	
	10.		Joseph Kaplan, M					Driv	e #22	21. F	Rockvill	e, MD	208	50	
47	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa				- "	-, 1		,			
	Registr		MAY 2. 2. 2	nne A.		in h	. N.	7							

		1	For State Registrar	State of Ma	arylan		rtment of			-	giene Reg. No.	200	6	15966
	Physicia	an	1. Decedent's Name (First, Middle	(Last) DOW	108	9			2	Date of De.	ath Day	Y	ear	3. Time of Death
	/Medic Examin	_	4a. Fecility Name (If not institution	give street and number)	,	Cente	4b. City, Town,	or Location of	11.	nove		County of	Death	11 141
	uneral irector		5. Social Security Number 499–10–3882			last birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. 8 Min.	Date of Bird (Month, Da 11y 24	th y, Year)		Birthpla Countr	•
death with the Maryland	fiel Hygiene. d other than "natural", or Ita	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Howar 10e. Street and Number	d		y, Town or Loc					10g. Citiz	en of Wh		d. Inside City Limits 1 Yes 2 XNo
3-0030 72 hours after death with		by Funeral	3004 North Ridg 11. Marital Status 1	12. Was Decedent Armed Forces? 1 Yes 2 ff ff Yes, Give Year or Dates:		If 1	2104. /as Decedent of Yes, specify Cu Yes 2X No	f Hispanic Ori iban, Mexican o Specify: upation	n, Puerto Rio	can, etc.)		4. Race - Black, Specify:	White, e	ic. Lte
KIKIO 1 within 72 iene		Completed	(Specify only highest Elementary/Secondary (0-12)		i+)	(Give k	ind of work don O NOT use retir	e during mos	t of working			Gove		
uld be filed		To Be C	17. Father's Name (First, Middle, Edward 0 Dowe							First, Middle, Law1e	. Maiden :			
e, Mary	tem 27 is ma		19a. Informant's Name/Relationsl John O'Dower 20a. Method of Disposition	nip (Type, Print) Son	20b. F	1501	Address (Street Vanhoe Ition (Name of	Avenue						,
Saltimor bermit. Pages	Important: If It any injury or o once.		1 XBurial 2 Cremation 4 Donation 5 Other (S) 21. Signature of Fundal Services	pecify)		thon Ce	metery Name and Add	ress of Facilit	5/27/2 _{ty} Ster]	006 (ing A	Custe	r Co 1 Sch	., 0k	1ahoma
ם פֿפֿ	any ii	Х	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lie	the deat	16	1	ondson ying, such as	Avenu cardiac or r	espiratory ai	tons	Inc. ville	í	21228 Approximate Interval Between Onset and Death
be executed	he he	dical Examiner	firmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cevel rovascular accident Month Mo									month years 4 days		
the death certificate	igned by the attending pl be detached for use as t	Physician/Med	ff FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1							2	3d. Date o		y Day Year
rds, P	n signed b ald be deta		Ditt	t conditions contributing to death but not resulting in the underlying cause given in Part !.						23e. Did tobacco use contribute to the cause o			1 A	
VITAL RECORDS, P.O.		Completed by	Hypertension Cardio myonathy							24a. Was autor perfo 1 \(\text{Yes} \)		prior to completion of cause death?		
OT VITA Physician:	this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	ant 2	ER/Outpatient	3□ DQA C			eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify)				
on or	or death.	ation: To	27. Manner of Death 1 Natural 5 ☐ Pendin	28a. Date of Injury 28b. Time of 28c. Injury at					28	28d. Describe how injury occurred				
UIVISION tal or Attending		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or		edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									he cause(s)		
2		×	29b. Signature and title of certifier 29c. License number 055-391						91	May 22, 2006				
15	1		30. Name and address of person	who completed cause of a	leath (fter	m 23a) (Type, F & M U &	rim) Bal.	time	re,	May	ylar	nd	21:	227
	Sta Registr		31. Date filed (Month, Day, Year)	005 22. Registr	ar's Sign	ature Anal	A STATE OF THE STA				,			,

	Physic /Med Exami
	Funeral Director
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene. important: if item 27 ie marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.

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10:20

2006

18,

Examiner

P.O. Box 68760, Division of Vital Records,

ANNA PRYOR

For State Registrar Decedent's Name (First, Middle, Last) May 18, ian 2006 Marie Pryor 10:20AM^M Anna cal 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ner Stella Maris Hospice Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 23, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 € F 212-03-9270 93 Yrs. Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Be Completed by Funeral Director Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7929 21236 U.S.A. Vernon Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specity: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Santo Ballistreri Cesina Corvaia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7929 Vernon Avenue Nottingham, Maryland 21236 Linda P. Brannan- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 5/22/06 Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. Heather Cain 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 alles 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Physician /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examiner ed by the attending physicien and deteched for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2X No To the Hospital or Attending Phyaician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 ▼ No 1 Inpatient 2 ER/Outpatient 3 DOA andin, or death. tor: After th. 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 2 ☐ Accident Injury 5 Pending 1 🗌 Yes investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Hornicide 29a. Certifier 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 118/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month Maly, Vea) 32. Registrar's Signature GORALA

Registrar

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		State of Maryland / Departn		ental Hygier	ne						
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Mary	2 a - 2 a -		19a. Informant's Name/Relationship (Type, Print) DEBORAH A. PAWLICKI (DA		ailing Address (Street and Number or Ri THEO ROAD, TOWSON,			lip Code)
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Division of Vital Records, P.O. Box 68760, To the Hospiral or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn	edical		Physician: To the best of maminer:On the basis of exa									
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Physician Marie Eleanore Rubenstein 3:45 P. May 18. 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Manor Care Woodbridge Valley 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🔏 F Days Hours Months 95 Nov. 6, 1910 Maryland Director 215-09-8252 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ed other then "neturel", or items 23a or 28a-f show event, the Mudical Exercises must be notified at 1X Yes 2 □ No Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21230 USA 1945 Griffis Avenue Pages 1 and 2 should be filed within 72 hours after death inent of Heatth and Mental Hygiene. Int: If item 27 is marked other then "neturel", or Items 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes 2 X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Wilhamina Bolm Edward Adolph Schnebelen ဥ treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Importent; If item 27 is eny injury or other tret once. 1795 Westchester Avenue; Catonsville, MD 21228 Joyce P. Davis Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation ☐ Other (Specify) Loudon Park Cemetery 5/22/2006 Baltimore, Maryland
22. Name and Address of Facility Sterling Ashton Schwab Witzke of Funer Service Liv Funeral Home of Catonsville, Inc. 11/01290 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part 1. Enter the akease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OVARIAN CANCER **Physician** METASTATIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 Yes 2 2 No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 🖫 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After To the Hospitel or Attending Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director; 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide

within 24 hours a

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day Xear)

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

210

2005 Registrar's Signature

BUSINESS CENTER DRIVE

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0059107

29d. Date signed (Month, Day, Year)

REISTERSTOWN MD 21136

			1 - For State Registrar	State of Ma	arylan				ealth a Death	and M		Reg. No.	06	159	72
7	Physicia		Decedent's Name (First, Middle, La Carl Leon Ro								2. Date of De Month May	Day	Year 2006	3. Time of 11:20	
	/Medic Examin		4a. Facility Name (If not institution, given				4b. City	, Town, or	Location of	of Death		4c. Cou	nty of Death		
			Rockville Nursin						ville				ntgome	3	
	Funeral Director		497-14-8619	Sex 7. Ag 1∭2 M 2□F	e (In yrs. i 82	last birthday) Yrs.		Days	If Under Hours	Min.	8. Date of Bi (Month, Di June 3	rth ay, Year) 0, 1921	9. Birth Cou Kan	place (State or intry) Sas	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside Cit	ty Limits
	Maryll f sho	lor	Maryland Montgom	erv	Roci	kville								1 X Yes	2 🗌 No
	r 28a	Director	10e. Street and Number	CLy	1100			ip Code				10g. Citizen	of What Cou	ntry?	
	th witi		504 Azalea Drive				20	850				United	State	es	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be uvitified at Apprex. Once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 I If Yes, Give Year or Dates:		1d	Was Dec If Yes, sp 1 \(\text{Yes}	ecify Cuba	ispanic Ori in, Mexican Specify:	n, Puerto F	cify Yes or N Rican, etc.)		Race - Ameri Black, White ocify: Wh:		
ğ	2 ho	ted	15. Decedent's E (Specify only highest gi	ducation		16a. Dece	dent's Us	ual Occup	ation during mos	t of workir	na .	16b. Kind o	f Business/Ir	ndustry	
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and	i be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Las									s, Marceri Sur	/airie/		
Ž	thould id Mei mark matic	ဥ	Homer Franklin 19a. Informant's Name/Relationship			19b. Maili	ng Addre:	ss (Street			e Linn Route Numb	per, City or To	wn, State, Zi	p Code)	
<u>⊠</u>	nd 2 s lith ar 27 is r trau		Virginia L. Merc			10824	Fox	Hun	t Lan	e. Po	otomac	, Maryl	and	20854	
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100	Physician		Immediate Cause (Final disease or condition	_a_ Cancer	of I	Prosta	te wi	Lth M	etast	asis				Oriset and L	76a(I)
	/Medical Examiner		resulting in death)	Due to (or as		·									
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on of	ie lie		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da	iry iy Ye <i>ar)</i>	28b. Time of Injury	of M	28c. Injur Wor 1 [yat k? Yes 2 ☐		8d. Describe	how injury or	curred		
Division	after des Director	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		jury - At h	ome, farm, st	reet, facto	ory, office		4		(Street and N оwп, State)	ımber or Rui	ral Route Num.	ber,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		hysician: To the best miner: On the basis of and manner st	of examina										;)
	To the within To the Youngle	Med	29b. Signature and title of certifier				2	9c. Licens	e number			29d. Date si	gned (Month	, Day, Year)	
			Avorners	V. So	uni	1		D004	7330			May 1	9, 200	6	
	vox,		30. Name and address of person wh	completed cause of	death (Iter	п 23а) (Туре	, Print)	S. Carlotte	OHIOTOCAS"			*			
	0		Thomas V. Joseph	, M.D. 50	West	t Edmo	nsto	n Dri	ve, R	lockv:	ille, l	Marylar	nd 20	852	
	Sta Regist		31. Date filed (Month, Day, Year) MAY 2 2 20	32. Regist	al a olgna	Age	1000								

DHMH 17 Rev 1/2001

			1 - For State of Maryland /	•	rtment tificate				giene Reg. No.	06	159	73
Ī	Physici /Medic		Decedent's Name (First, Middle, Last) John B. Riggs					2. Date of Dea Month May 15	Day	Year	3. Time of 0 4:45	Death AM
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, To	wn, or i	ocation of Dea	th	4c. County	of Death		
		1	Wilson Health Care Center				sburg			ntgom		
1334	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b) 225-46-4984 87	Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min		, 1918	9. Birthp Cour Man	place (State or htry) yland	Foreign
	land ow		10a. State 10b. County 10c. City, To	wn or Loc	ation					1	0d. Inside City	Limits
	Many Be-fah	tor	Virginia Loudoun	Le	esbur	g					↑ □ Yes	2 X]No
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23s or 28e-f show any injury or other treumatic event, "In Medical Exam net must be multiped at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give WW II		/as Deceder Yes, specify			Specify Yes or No- rto Rican, etc.)	14. Rad Bla	e - Americ ck, White,	etc.	
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	Physician /Medical Examiner		23a. Part 1. Enjer the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence Sequentially list conditions		r the mode o	of dying,	such as cardia		rest,		Approximate Interval Betwee Onset and De	een
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	11		MA Labert Freschbar	ELS]	2	001	+115	/	May.	5,0	006	
	1541		30. Name and address of person who completed cause of death (Item 23)	(Type, P	rint) Z	1/	RUSS THER	ELLA. SSCLRK	ENU,	208	77	
	Sta Registr		31. Date filed (Month, Day, Year) MAY 2 2 2006 32 Aegistrar's Signature	100	and I							

Maurice Lionell Russell

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State of Maryland / Department of Health and Mental Hygiene

viadrice Lioneli (ta	1	1. For State Registrar State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. Reg. Reg. Reg. Reg. Reg. Reg. Reg.	No. 2001	1597
Physician	1	1. Decedent's Name (First, Middle,Last) 2. Date of Death		3. Time of Death
Medical Examine	٠.	May 14, 2006	6	0812 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Woodlawn	4c. County of Death Baltimore Cou	ntv
Funeral	7		MM/DD/YYYY) 9 Birti	•
Director		217-27-9813 1×M 2 F 23 Yrs. Months Days Hours Min.	Foreign Cou	Maryland
	- 1-	Usual Residence of Decedent	7 (70%)	0-C//
w any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
yland a-f she Lonce	ē.	Md- N/A SACTIMORE 10e. Street and Number 10f. Zip Code 10g. Cip Code	Citizen of What Coun	1 X Yes 2 No
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9, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene ten 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Lane	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americ White, etc.	
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Baltimore permit. Pages 1 Department of H Important: If i	1	Signature of Funeral Service licensee 22. Name and Address of Facility	"nommitie	715
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18760, rtificate be ming physic as the bur			23d. Date of delivery Month Da	ay Year
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Division or Strending hours after death. Incra Director: After filled in by the fune.		3 V Suicide 6 Could not be determined (Specify) Park 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Park 28f. Location (Stree or Town, State)		
Spi File bound	۲ - ا	4 Homicide Gwynn Oak Pal 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)	rk, Woodlawn, N	
To the Ho within 24 I To the Fu completely		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated		
L × L o	≝	29b Signature and Me of certifier 29c. License number 29c	d Date signed (Mont	h, Day, Year)
	-	oc.M.E. M	lay 15, 2006	
		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
Stat	æ			
Registra		to A a Miles		
DHMH 17 Rev 1/200	1	ORIGINAL		

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Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)						1	2. Date of Dea				Time of Deat	th
ledical Exami	ner	Avon Richards								Month April 29, 2	Day 2006	Year		1230 hrs	
and the same of th		4a. Facility Name (if not institution		number)			City, Town, or	Location o	of Death		4c.	County of	Death		
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Funeral		5. Social Security Number unk	6. Sex	7. Age (In yrs.	last birtho		If Under 1 Year Months Days		r 24Hrs. Min.	8. Date of Bi	rth (MM/E		9. Birthpla Foreign		unk
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ith wi	uneral	11. Marital Status un			ink		Decedent of His specify Cuban)-	14. Race - White,		Indian, Blac	К,
er dez	ഥ		1 Yes	2 No		1 🗆 V	es 2 X No	enecify:				Specify:	h1	1_	
rs aft ural"	<u>ā</u>	15. Decedent's Education (Spe	or Dates:		16a. De		Usual Occupati		kind of wo	rk done			blac iness/Indu		
2 hou "nat	ğ	Elementary/Secondary (0-12)		(1-4 or 5+)			of working life.			d)				,	
)36 thin 7 than than	힐	unk	unk							unk			unl	C	
5-0036 iled within 7' Hygiene. I other than	Completed	17. Father's Name (First, Middle				11	nk 1	18.Mother	's Name (First, Middle,	Maiden S	Surname)			. 1
21215 uld be file Mental H marked c event, I	Be					u								u	ınk
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f 3he marite event, the Medical Examiner must be notified at once	ျ	19a Informant's Name/Relations	hip (Type, Print)				ddress (Street						State, Zip	Code)	
and 2 shou lealth and N tem 27 is n traumatic	- 1	O.C. M. E.					nn Stre								
re, M s 1 and 2 f Health if item 2 er traum	- 1	20a Method of Disposition 1 Burial 2 X Cremation	3 Removal		Place of cremator		n (Name of cen place)	netery,		Date	20c. L	ocation - (City or Tow	n, State	
MOF Pages lent of l		4 Donation 5 X Other 3		1 1	etro Cr	emato	ry		6/9/2	006	Balt	imore	. MD		
Baltimore, permit Pages I ar Department of Hee Important: If ite	1	21. Signal e Luneral Service Ronald S	Licensee	irector			ne and Address				s Fur	eral I	lone	1300 Eur	taw P
0 5 2 5 5		/ sman/	// ///	all							• Ba	1. C 1 in	ore b	treet	
Physician		Baltimore, MD 21201 ZIZIV Sa. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate In Between Onse													
/Medical		mmediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death													
		or condition resulting in death)	Due to (or as	a consequence	of):										
Nagar of	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):						_	_	\rightarrow		
	ij	cause Enter Underlying Cause		a consequence	01).										
T .5	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):										
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O, e be exi	Ψ,	UNPENDED		item#20		,perr	H,G856,6/	/13/06	TT		-		_	-	
Box 6876(c) death certificate the attending phy ed for use as the b	Physician/M	IF FEMALE: 23b. Was oecedent pregnant in t		s, outcome of pre birth	egnancy	Fetal	death 3	Ectopic	pregnan	CV		. Date of d Month	lelivery Day	Ye	ar
x 66 h cert tendir use a	icia	past 12 months?	4 Pres	gnant at time of o	death 5		(Specify)		F 5	,	4		,		-
BO) e deat the at ed for	hys			nown											
P.O. E es that the cigned by the edetached	by P	Part II. Other significant condit	tions contributing	to death but not	resulting i	n the und	lerlying cause g	iven in Pa	art I.					cause of dea	
- 88 - 50 e	be be	Neoplasm										No 3	Probably	/ 4 ✓ Unk	.nown
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been si led in by the funeral director, page 2 should t	Completed									24a. Was autor				y findings av	
Reco The law icate has	Ĕ									perfo	rmed?	de	eath? Yes	_	No
tal Rectian: The certificate ector, page	യ	25. Was case referred to medica	1				26 Place	of Death	(Check or			1 . 6			
Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Out	patient 3	B DOA	Other ₄	Nursing	Home 5	Resider	nce 6 🗸	Other: Sc	ene	
n of ling Ph After funeral	Ë	27. Manner of Death	28a. Da	te of Injury hth, Day,Year)	28b. Ti	ne of Inju	ry 28c. Injur	y at Work	? 2	8d. Describe	how injur	y occurred	d		
ion tendi eath.	1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 1 Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								No						
Vis or At fter d Direct in by	iţi			ace of Injury - At	home, farr	n, street,	factory, office b	uilding, et	c. 2	8f. Location (or Town, 5		id Number	or Rural F	Route Numbe	ər, City
Div pital or ours afte eral Diu	Sert	4 Homicide	rmined (Specif	y) .						01 10401, 0	- Late)				
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	al ((Olicon ora)	hysician: To the b												
To the Hos within 24 h To the Fun completely	edical	- [-	miner:On the basi and manner		and/or inv	estigatior			curred at	the time, date					
[, []	Š	29b. Signature and title of certific	er ~				29c. License						d (Month,	Day, Year)	
		(della	104	5			O.C.1	VI.E.			April	30, 200)6		
		30. Name and address of person		`	,	_									
			Assistant Med			Penn	Street, Balti	more, N	иD 212	01					
	ate			Registrar's Signa	ature		and the same		-						
Regis	TET	MAY 2 2	2006 42	March College College	The state of										

			State of Maryland / Depart State Registrar State Of Maryland / Depart Certification		•	ne 2006	15976
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici		Gregory Scott Steal	ev. Sr.		pay Year	11:54 A M
	_/Medic			b Sity, Town, or Location of Death		4c. County of Death	11.5-17.
	Examin	er		Locadale		Baltimo	NO .
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	f Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birtholi	ace (State or Foreign
	Funeral Director			fonths Days Hours Min.	8. Date of Birth (Month, Day, Yea July 24.]		ace (State or Foreign ry)
			Usual Residence of Decedent		JULY 24,1	L930 Mary	Land
	/land		10a. State 10b. County 10c. City, Town or Locati	ion		10	d. Inside City Limits
	urs after death with the Marylar sl', or Itams 23a or 28a-f show Evanting must be trefffed at	to	Maryland Baltimore	Dun	dalk		1 ☐ Yes 2/XNo
	or 285	Funeral Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Count	ry?
	h with	<u>E</u>	7303 School Avenue	21222	τ	United Sta	tes
	er death w Itams 23a ner must	ner		s Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - America	
29	after or Ita	Ē	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Yes 2 No Specify:	ricari, etc.)	Black, White, e	ac.
08	within 72 hours after death with the Maryland ene. then "natural", or Itams 23s or 28s-f show he Medical Evaminat must be inclified at	1 by	3 Widowed 4 Divorced Year or Dates:	163 ZIM 140 Specify.		Specify: W	hite
25	72 hours 'natural',	etec	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kin.	t's Usual Occupation d of work done during most of worki NOT use retired)	16b.	. Kind of Business/Indi	ustry
72	ithin	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)			
₩	D CO	Completed by		hanic	(F) . A 6 1 (A 6 1)	Automoti	ve
		Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	en Sumame)	
× ×	2 should be and Mental Is marked of aumatic sve	70	Charles R. Stealey		E. Wagner		
Aar (s 1 and 2 should f Health and Men itam 27 Is marke other traumatic		1.121	Address (Street and Number or Rura School Ave. Dun	al Route Number, City dalk, Mary		
2.	1 and 2 Health sam 27 l		THE THEY SEE STORES (TELLY	2.4		Location - City or Tov	
7 5	000		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State				
Saltim		1		ervice Corp. 5/2	2/2006	Towson, Ma	ryland
3al	permit. Departn Imports any inju		Di (Di	ame and Address of Facility da-Ruck Funeral	Home of Du	undalk, In	C. 1222
	70 5 8 0		Tylligan Clark 79	922 Wise Ave. Du	undalk, Ma	aryland 21	
			23a. Part1. Enter the distase, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line.	ne mode or dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death) a. SOPIC Shock	<u> </u>			
	/Medical Examiner		Due to (of as a consequence of):	D.CC 11- (111		
	ZAGITITIO		Sequentially list conditions, b. C105m1C1tum	NIHICIE (Ontis		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be in indealth) act.	Bacteremia	CA		
	and I-trar	xan	that initiated events resulting in death) Last Due to (or as a consequence of):	Dictording			
760,	be executed sician and burial-transit	calE					
687	a × a		d				
× 6	leath certificat attending phy I for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	
Вох	atten for u	ian	in the past 12 months?	topic pregnancy ther (specify)			Day Year
P.O.	at the de by the	Physician/Med	1 Yes 2 No 9 Unknown				
	Physician: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th		Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ds	uires sign ld be	d by	Cirrhosis,		1 🗆 Yes	2 No 3 □ Proba	ably 4 Unknown
Š	w requires that s been signed b should be det	ompieted	Bheilmatoid Arthritis		24a. Was an	24h Were autor	esy findings available
Re	has ge 2	Ę	11001.40.0		autopsy performed?	prior to com death?	pletion of cause of
<u></u>	n: Th ficate fr, pa	O	Hepatitis C	00 81 (5	1 Yes 2	No 1 Yes 2	2 No
₹	Physician: The la t this certificate ha ral director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	Other	h (Check only one)	6 ☐Other (Specify)	1
ō	Phy r this ral d	-	27. Manne of Death 28a. Date of Injury 28b. Time of	3 COA 4 Nuising No	28d. Describe how in		/
on	ding Ph th. After thi funeral	ţ	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Atten ifter deat Diractor: in by the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	, factory, office	28f. Location (Street	and Number or Rural	Route Number,
Div	after Dire	Certification:	4 Homicide building, etc. (Specify)		City or Town, Sta	110)	
	hours inara y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	ocurred at the time, date and place,	and due to the cause	(s) and manner as sta	ated.
	To the Hospitel or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or invesored and manner stated.	tigation, in my opinion, death occurr	eu at the time, date a	ing place, and due to	tne cause(s)
	To the To the Comp	ž	29b. Signature and title of contiller	29c. License number	29d. [Date signed (Month, D	Day, Year)
			Myx	D005-62	96 5	116/20	006
- /.	- 8		30 Name and address of person who completed cause of death (Item 23a) (Type, Pri		0	1	01
2)		Dr. Jason Brnaum 9000 Frank	Lin Square Uri	ve bath	more Md	21237
	Sta Regist	ate	31. Date filed (Month, Day, Year) MAY 2, 2, 2006 32. Registrar's Signature				

DHMH 17 Rev 1/2001

		-	1 - For State Registrar	ate of Maryland		artment of tificate of				ene g. No:	6	15977
-		, š	1. Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		DAISY MAE	SMITH						18 20	06	7:15 a ^M
1	Examir	er	4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town,	or Location of	of Death		4c. County	of Death	
46			2119 BOLTON STREE			BALTI		6411		N/		
	Funeral		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. ia		If Under 1 Yea Months Days		Min.	8. Date of Birth (Month, Day,		Cour	
-3.	Director		405-36-6843 Usual Residence of Decedent	0.	9 110.				JAN 17	191/	KEN	TUCKY
	and land		10a. State 10b. County	10c. City	Town or Lo	cation					1	0d. Inside City Limits
	-f sh	ğ	MARYLAND N/A			BALTIMO	RE					1XX es 2 □ No
	1 the	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of W	/hat Cour	ntry?
	N with	O E	2119 BOLTON STREET	1		2	1217			U.S.	Α.	
	deat	Funeral	11 Marital Status 12. V	Vas Decedent Ever in U.S med Forces?	3. 13.	Was Decedent of f Yes, specify Cu	Hispanic Ori	gin? (Spe	cify Yes or No-		- Americ	can Indian,
9	or Ite	교	1 Never Married 2 Married 1	☐Yes 2X No Yes, Give		1☐ Yes 2፟ X X		.,	tiouri, otory	Specify		otc.
21215-0036	72 hours after death with the Maryland natural, or Itema 23e or 28e-f show iteal Examinational be incilled at	d by	3 ⊠ Widowed 4 □ Divorced	ear or Dates:							BLAC	
5-	nati	Completed	15. Decedent's Educatio (Specify only highest grade cor	n npleted)	16a. Deced	dent's Usual Occi kind of work don DO NOT use retir	upation e during mos: rod!	t of workir	ng	6b. Kind of Bu	siness/In	dustry
121	within ene. then	E D		College (1-4or 5+)			90)			SELF		
	filed Hygie Sther	ပ္ပ	8th grade 17. Father's Name (First, Middle, Last)		DOME	STIC	18. Mothe	er's Name	(First, Middle, M		e)	
Maryland	d tal	o Be	LUTHER WHITE					MI SO			-,	
2	should and Men a marke umatic	F	19a. Informant's Name/Relationship (Type, I	Print)	19b. Mailir	na Address (Stree			l Route Number,	City or Town.	State. Zic	Code)
<u>∞</u>	id 2 s ith ar 27 is 1 trau		Marva J. Lowery/Daug			•			more, Ma			
e,	Health tem 27 ther tr		20a. Method of Disposition			sition (Name of natory or other pi				Oc. Location -		
2	Pages nent of t int: if its		1X Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	Val IIOIII State		Cemete:		05-22	2-06 L	ANSDOWN	JE. M	IARYLAND
Baltimore,			21. Signature of Fangal Agrica Lider See	110	22	. Name and Add	ress of Faculit	lv			-12-11-27-11	
B	permit. Departr Importa any Inji) / / July NA	um	W3	LLIAM C	BROWN RTH AV	COM ENUE	MUNITY F	UNERAL	HOME	P.R.
13			23a. Part 1. Enter the disease, or complication	ns that caused the death.					r respiratory arre	st,		Approximate Intervat Between
	Physician •		shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.	1.000	00 0	. ~		h.			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		ST CAN	16715					ZyEAS
	Examiner											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):							
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó,	e exe	E	resulting in death) Last	Due to (or as a consequ	ence of):							
68760	The law requires that the death certificate be executed site hes been signed by the attending physicien end page 2 should be detached for use as the burial-transit	lical	d									
9	eath certifica attending ph I for use as ti	Me	IF FEMALE:	f yes, outcome of pregnar			·					
Box	ath c attend for us	lan	in the past 12 months?	i yes, outcome of pregnar I □Live birth = 2 □ Fetal I □ Pregnant at time of de	death 3	Ectopic pregnan	ісу			23d. Date Mor		ery Day Year
P.O.	the de	Physician/Med		i⊟Pregnant at time of de 9⊟Unknown	am sc	Other (specify)						
	res that the de signed by the a l be detached f		Part II. Other significant conditions contribu	iting to death but not resu	lting in the u	nderlying cause o	given in Part I		23e. Did toba	acco use contr	ibute to t	he cause of death?
Records,	uires sign ld be	d by							1 🗀 Ye	s 2 🗆 No	3 🗌 Prob	pably 4 Donknown
Ö	w require been sl	Completed							24a. Was an	24b. V	Vere auto	psy findings avaitable
Re	ding Physician: The lav h. After this certificete hes funeral director, page 2.	E E							autopsy perform	ed?	rior to co leath?	impletion of cause of
Vital	ificeta	ပိ	25. Was case referred to medical				GC Disco	of Dooth	1 Yes 2		Yes	2 No
S	Physician: this certifice ral director, i	ToB	examiner?	tal: 1 Inpatient 2 E	R/Outpatier	t 3 DOA	ther		ne 5 Resider		ar (Snecil	ty)
ō	a Phy er this		27. Manner of Death		28b. Time o				28d. Describe how			7/
ion	ndin Ith: R. Afe	atio	1 Aaturat 5 Pending 2 Accident investigation	(MOHHI, Day 1941)	Injury		Yes 2	No				
Division	or Attending after death. Director: Afte in by the fune	ji ji	3 Suicide 6 Could not be determined 2.	Be. Place of Injury - At hor building, etc. (Specify,	me, farm, str	eet, factory, offic	е	2	28f. Location (Str. City or Town,		er or Rura	al Route Number,
Ö	s afte	Certification:	4 - Normolds	building, etc. (Specify,	,				Ony or Town,	State)		
	ospit hour uner ly fill		29a. Certifier 1 Certifying Physicia (Check only 2 Madical Examiner:	n: To the best of my know On the basis of examinati	vledge, deat	occurred at the	time, date an	d place, a	and due to the ca	use(s) and mai	nner as s	tated.
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	one)	and manner stated.	on and or in			un occurre	-			
	To To	2	29b. Signature and title of certifier	140		1125	nse number	_		d. Date signed		
	4		JKWW	L /\2		17.7	21116)		5-19	1-0	6
1	0		30. Name and address of person who comple	eted cause of death (Item	23а) (Туре,	Print)	0	, , ,	11 7	7		
			JKWIIS PD 1	32. Registrar's Signat	ROY	of Ave	BA	17 1	16 L	1217		
	Sta Regist		31. Date filed (Month, Day, Year)	A Comment	ui e	as also						
1	icaist		MAY 2 2 2006	frank parties of	and the same							

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				State of Maryland / Departm State of Maryland / Departm Certific	ent of He cate of D	eath	Re	g. No.	15978
		Physicia		Docedent's Name (First, Middle, Last) DOROTHY MAY SHIPLEY		-	Date of Death Month M2 Y	Day Year 13 2006	3. Time of Death 2:08P M
		/Medic Examin			_	ocation of Death		4c. County of Death	
		Funeral Director	(10°	5 Social Security Number 6, Sex 7, Age (In yrs, last birthday) If L	Inder 1 Year oths Days	Hours Min.	Date of Birth (Month, Day, OV. 12	Year) Cou	place (State or Foreign intry) ARYLAND
		yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1				10d. Inside City Limits 1 X Yes 2 No
		death with the Maryland ms 23a or 28e-f show r must be todiffed at	Director	MARYLAND N/A BALTIMOR 10e. Street and Number 10	E of. Zip Code		10	Og. Citizen of What Cou	
		th with	ai Dir	3608 COTTAGE AVENUE	2121			U.S.A.	
hope	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiens. Importants if Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Medical Examinar must be colified at any injury or other traumatic event, Ite Medical Examinar must be colified at any injury or other traumatic event.	by Funerai	1 Never Married 2 Married 1 Yes 2 TVN	Decedent of His , specify Cuban es 2 X No	panic Origin? (Speci , Mexican, Puerto Ri Specify:	ty Yes or No- can, etc.)	14. Race - Amer Black, White Specify: BL	, etc.
خ	215-0036	in 72 ho "natur edical	Completed	life. DO N	Usual Occupat of work done du OT use retired)	tion uring most of working		16b. Kind of Business/I	ndustry
2	N	filed withi Hygiene. other ther	Com	Elementary/Secondary (0-12) 12th grade College (1-4or 5+) COOK 17. Father's Name (First, Middle, Last)		18. Mother's Name (First Middle N	FOOD SER	VICE
zipl.	Maryland	uld be fil fental H rked ott	To Be	ARTHUR ATKINSON			TKINSON		
15	Mary	12 should in and Men 7 is marke		Jac. Highlight Charles of Party Constitution of the Constitution o	•			City or Town, State, Z ce, Marylan	
		ss 1 and of Health Item 27		20a. Method of Disposition 20b. Place of Disposition	(Name of	Da		20c. Location - City or	
	Baltimore,	t. Pages rtment of I rtent: If It njury or o		1 🖾 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of France 1 Solve Light Rep	1 4 4 1	05-23		LANSDOWNE,	
	Ba	permit. Departn Importe any inju		Leveur WILI 1206	IAM C E W NORT	BROWN COMM TH AVENUE		FUNERAL HOM	
	100	Physician		23a. Part 1. Enfance disease of complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Stanh Awen, Pu	mode of dying	, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onserand Death
		/Medical Examiner		Due to (or as a consequence off:	7014				10 years
	8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
	P.O. Box 6	ne death certiff the attending I hed for use as	Physician/Me		opic pregnancy er (specify)			23d. Date of deli Month	very Day Year
		quires that the signed by old be detacted	þ	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause give	n in Part I.	23e. Did tol	bacco use contribute to es 2 \(\text{No} \) 3 \(\text{Pri}	the cause of death? obably 4 _Unknown
	I Reco		Completed				24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of
	Vita	sicien: certific rector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	3□ DOA Othe	26. Place of Death		ne) ence 6 ⊡Other (Spe	city)
	Division of Vital Records,	nding Physath. r: After this se funeral di	 -	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Injury	28c. Injury Work			ow injury occurred	,
	Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)			City or Tow		
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		To the Within To the	Me	29b. Signature and title of certifier	29c. License			29d. Date signed (Mont.	
		1		30. Name and andress of person who completed cause of death (Item-23a) (Type, Prin	t)	7 6 3 67		عال الربي الم	Baltimary M
	3	St Regis	ate	31. Date filed (Month, Day Year) 2 2 2002. Registrar's Signature	inth s	+ Boltimo	re, 24	or w. Below	Ne, 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 18 per fh 9855 5-23-06 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 Month MAY Physician LONNEY TYRONE STEWART 20, 11:10A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3618 GWYNN OAK AVE, APT 2 BALTIMORE CITY N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F 55 Yrs. "ČAROLINA 218-56-1008 N. Director 02/08/1951 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r then "naturel", or Itema 23a or 28a-f show the Medical Examinational be confilled at 1 XYes 2 □ No MD N/A Director BALTIMORE CITY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3618 GWYNN OAK AVE, APT. 21207 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after Il Hygiene. other then "naturel", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US POSTAL Elementary/Secondary (0-12) College (1-4or 5+) SERVICE TRANSFER CLERK 12TH or other traumatic event, te. Mother's Name (First, Middle, Maiden Sumame)
KATE_ROBINSON 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event gotes. Be BENJAMIN STEWART 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) 3618 GWYNN OAK AVE, APT 2, BALTIMORE, MD BRENDA STEWART / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEM. PARK 5/27/06 4 ☐ Donation 5 ☐ Other (Specify) WINDSOR MILL, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD ear. Enter the disease, or complications that cause shock, or head failure. List only one cause on each d the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2410 motoutate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ 10 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide within 24 hours a

To the Funeral i

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier com 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Davis m 5601 Halu 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 2 2006 Before Si Registrar

			1 - For State Registrar	State of Ma	aryland	-	artment			ind Me		61	006	15980
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	Funeral Director		5. Social Security Number 213-26-2456 Usual Residence of Decedent	ex 7. Age	o (In yrs. Ias 75	t birthday) Yrs.	If Under Months	1 Year Days	if Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Feb. 28	Year) , 1931	Coun	lace (State or Foreign ity) /land
	the Maryland 28a-f ehow	rector	10a. State 10b. County Maryland Carroll 10e. Street and Number		10c. City, 1	own or Lo		Code			1	0g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 No
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "netural", or items 23a or 28a-f ehow amply injury or other traumatic event, the Madical Examinar must be multipd at ance.	Completed by Funeral Director	2817 Ridgeleigh (11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates:	10		1 ☐ Yes 2	2 <mark>⊠</mark> No	spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	offy Yes or No- lican, etc.)	Specif	y. 	etc. nite
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Baltimore, M	t. Pages 1 and 2 rtment of Health rtent: If item 27 I njury or other tre		Michael Stewart, 20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification of Specification val from State	cem	e of Disponetery, crer	sition (Name of the Ceme)	ne of ther place tery	9) 5	/23/0	06 1	20c. Location	City or To	wn, State aryland	
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760,	Physician and // Medical Examine prival into prival items in the p	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. End Due to (or as b. Due to (or as c. Due to (or as d.	St cansequent	nce of).	De	m	en	tia				Onset and Death
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				For State	State of Ma	aryland	•		lealth and N	nental Hy	giene		
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			For State	State of Marylan		nt of Health and <mark>I</mark> te of Death	Mental Hygie		15982
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physicia /Medic		CORNEL	lus st	ENCER		Month OF	B 2000	6 3:13 PM
	Examin		4a. Facility Name (If not institution, give s	spital	4b. 8	and all Sto	wn	4c. County of Deal	Hmore
	Funeral Director		5. Social Security Number 6. Sex 216-52-0442	M 200 F 7. Age (In yrs. 55	last birthday) If Und Yrs. Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Y	9. Bird 750	thplace (State or Foreign buntry)
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examilier must be notified at ance.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates:	.S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
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	Sta		31. Date filed (Monthy Dey, Year)	12. Registrar's Signal		10 W 9 C			
	Registr	ar	2000	Alexander Alexander					

			For State Registrar	State o	f Marylan		artment of tificate o				giene Reg. No.	006	15.	383
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Ş	thou sture	ed	15. Decedent's	Education		16a. Deced	lent's Usual Oc	cupation			16b. Kind	of Business/In	ndustry	
215	within 72 lene. then "net	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	I-4or 5+)		kind of work do OO NOT use ret	ne during mo tired)	ost of worki	ng				
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Maryland 21215-0036	be file tal Hy d oth	To Be	17. Father's Name (First, Middle, L							(First, Middle,		ımame)		
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a M	d 2 st th and 7 is n traun	P	19a. Informant's Name/Relationshi Charles D. Sham		and		ng Address <i>(Stre</i>) Wether				•			
نة	1 and Heeti Iem 2		20a. Method of Disposition	<u> </u>	20h P	lace of Disno	sition (Name of			-		tion - City or T		
Baltimore.	permit. Pages 1 and 2 should be filed within pepartment of Heeth and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Managare.		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	State Cry	emetery crem rstal S netery	prings	olace)	May 200)6	Missi	al Spri ssippi		
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ο 6 ο 4 0.0 Box 66	death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live b	tcome of pregna pirth 2 Fetal pant at time of de own	Ideath 3□	Ectopic pregna Other (specify)				230	1. Date of deliver Month	•	ear
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ita	slcien: Th certiticete rector, pag	Bec	25. Was case referred to medical examiner?					26. Plac	ce of Death	Check only				
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	the street		27. Manner of Death 1 Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury		njury at Work?	į.	28d. Describe	how injury o	ccurred		
RA Sion	Attending r death.	cati	2 Accident investiga 3 Suicide 6 Could no	ot be	at laive. At he			Yes 2		28f. Location (Ctmat and A	lumbas as Dua	al Paula Mumb	
BARA Division	or At atter of Direction by	Certification;	4 ☐ Homicide determin		of Injury - At ho ing, etc. (Specif)		eet, ractory, oni	Ce		City or To	wn, State)	rumber or Hure	ar Houte Numi	167,
AR	Hospita 4 hours Funerel	edical Co	29a. Certifier 1 Certifying (Check only one)	Physician: To the b	e best of my kno asis of examina ner stated.	wledge, death	n occurred at the vestigation, in m	e time, date a ny opinion, de	and place, a	and due to the ed at the time,	cause(s) an	d manner as s	stated. o the cause(s)	
3	To the within 2 To the complete	Med	29b. Signature and itle of certifier	2 h	nor stated.		29c. Lice	ense number	19		29d. Date s	igned (Month,	Day, Year)	
	10		30. Name and address of person w	no completed caus	se of death (Item	n 23a) (Type,	000			getown				
	Sta Registr		31. Date filed (Month, Day, Year)	A.d.	tegistrar's Signa	iture	Bet	nesda,	, mary	land 2	0014			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 13, Haw-Chun Sun 2006 12:49 A May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | January 31, 1950 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 1 X M 2 □ F 213-02-8643 Taiwan Director 56 Usuel Residence of Decedent with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County in then "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 7800 Fairborn Court 20855 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Server Country Club permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy important: If Item 27 is marked other eny Injury or other trainment. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wei-Jean Sun /Wife 7800 Fairborn Court, Rockville, Maryland 20855 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition May 22, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. Mosketter M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part. (Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown s been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Punknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No certificete 1 ☐ Yes 2,527No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2)€ No 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 1 ☐ Yes To the Hospital or Attending Phywithin 24 hours efter death.
To the Funaral Director: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ello 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OI Kowwiew 11119 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2006 Registrar

		H	State Co	artment of Health and Menta rtificate of Death	al Hygiene	5 15985
		On 7	Registrar 1. Decedent's Name (First, Middle, Last)	2. Da	te of Death	3. Time of Death
次	Physicia	an	Charlie C. Smith	Mo	May 16, 2006	6:52 P ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	th
2			4211 Kenshaw Avenue	Baltimore	N/A	
**	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 84 Yrs.	Months Days Hours Min. (M	onth, Day, Year) Co	thplace (State or Foreign ountry) rth Carolina
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	Aaryla Fahor ed al	٥				1) (∑(Yes 2 □ No
	the 28a-	Funeral Director	Maryland N/A Baltimon	10f. Zip Code	10g. Citizen of What Co	ountry?
	N with		4211 Kenshaw Avenue	21215	U.S	S.A.
	deat	ner	11 Martial Status 12, Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,	es or No- 14. Race · Ame etc.) Black, Whi	
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nd	tal Hygier d other	Be	17. Father's Name (First, Middle, Last)		, Middle, Maiden Sumame)	
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Maryland	12 s h ar 7 ls treu				reek. Californi	
	1 an Hea Hea tem	'	20a. Method of Disposition 20b. Place of Disp		20c. Location - City or	G 5 1001
JOE	0 0	1	1 M Burial 2 ☐ Cremation 3 ☐ Removal from State	dge Cemetery 5-20-20	06 Pikesville	Maryland
Baltimore,	permit. Pag Department Important: I any Injury o			and the second s	Towson Funeral	
Ö	9 0 E 2 0		tank Witagan	1050 York Road To	wson, Maryland	21204
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or resp	iratory arrest,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	an alter dival	,	
	/g	70	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):		4	
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-	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)		
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ds	fuires n sign ald be	d by	Parkinson's dikak		1 ☐ Yes 2 ☐ No 3 ☐ F	robably 4 Unknown
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ita	ian: artifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che	nck only one)	
) V	Physician: r this certificantal director.	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Residence 6 Other (Sp.	ecify)
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isic	Attending r death. Sctor: Afte by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office 28f. L	ocation (Street and Number or F	Rural Route Number,
Ο̈́	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)		ity or Town, State)	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea (Check only 2 Medical Examiner: On the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of examination and/or in the basis of my knowledge, dea	ith occurred at the time, date and place, and di	ue to the cause(s) and manner a	as stated.
	the Hin 24 the Fu	Medical	one) and manner stated.			
	To To	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	KO
	2		and the second s	Print)	/ 0 /	1 10
İ	UX		30. Name and address of peyson who completed cause of death (Item 23a) (Type	yoos old Con	it Rd; Hall	Fort of The
4	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			-
	Regist	rar	MAY 2 2 2006	350		

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		-	State of Maryland 1 - State of Maryland Per FH G855 5/3:	/ Department of He 1/06 CG Certificate of D	ealth and Mental Death	Hygiene,	15987
	0		1. Decedent's Name (First, Middle, Last)			of Death	3. Time of Death
	Physicia		ISA TAH	1/4	ILLEY MA	th Day Yea	6 1:27 AM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. Gity, Town, or L	ocation of Death	4c. County of D	
			The Johns Hopkins Hospita	al BAHIM	OLE	N	A
	Funeral Director		5. Social Security Numbe 0746 6. Sex 7. Age (In yrs. las	t birthday) If Under 1 Year Months Days	Hours Min. 8. Date	of Birth 9. I	Birthplace (State or Foreign Country)
			Usual Residence of Decedent			(1140)	
	ylanc Mow			Town or Location			10d. Inside City Limits
	Mar	tor	MD NIA B	altimore			1 SYes 2 No
	172 hours after death with the Maryland "naturel", or Items 23a or 28e-1 ehow after Exactinat must be notified at	Director	10e. Street and Number	10f. Zip Code	12	10g. Citizen of What	Country?
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	er de Items	Funerai	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married	If Yes, specify Cuban	panic Origin? (Specify Yes , Mexican, Puerto Rican, el	ic.) Black, W	merican Indian, hite, etc.
36	Ir. or	by F	1 ☐ Never Married 2 Married 1 Marri	1 ☐ Yes 2 XNo	Specify:	Specify: 1	31ack
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Maryland	2 should be and Mental I s marked o	2	Frank-Toll-ey		Josephine		
Nar	s 1 and 2 should f Health and Mer tem 27 Is marke other traumatic		19a. Informant's Name/Relat Inship (Type, Print) Geraldine Talley/Wife	19b. Mailing Address (Street and	ette StVeet		a, Zip Code)
	is 1 and 2 of Health item 27 other tra			ce of Disposition (Name of	Date	Balto MD 20c. Location - City	or Town, State
٥	00		1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State	netery, crematory or other place, NNSVIIC VA	05.23.00	^	
altimore,			`4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee				
B	permit. Departr Importe any inju		Bà Clato Moise	3 Haugher York	Road Baltin	val Schlico Ione MD 2121	2.
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequent	nce of):			23 15-71 2
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1,	ecute and -trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequer	noe of):			
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o.	at the de by the tached	Physician/M	1 Yes 2 No 4 Pregnant at time of deal 9 Unknown 9 Unknown	,,			
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<u>></u>	ys d	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ EF	R/Outpatient 3 DOA Other	4 Nursing Home 5	Residence 6 Other (S	pecify)
J of	€ € ख		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year)	8b. Time of 28c. Injury a Work?	at 28d. Des	cribe how injury occurred	
Ö	uttendir death. ctor: Af y the fur	atic	2 Accident investigation		es 2 No		
Division	l or Att after de Direct d in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Loca City	ation (Street and Number or or Town, State)	Rural Route Number,
	pitel (urs al arel D illed it		On Continue of Continue Desire		a data and slave as the	to the same to be	
	Hosi 24 ho Fune etely f	Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of my knowl (Check only one) 2 ☐ Medical Examiner: On the basis of examination and manner stated.				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune	Me	29b. Signature and title of certifier	29c. License	number	29d. Date signed (Me	onth, Day, Year)
	> - 0		20-10111 40	060-	000	Va BY 11	2 0001/-
	10		30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print)	000	11/11/16	2006
	10		WILLIAM T. ALLAGO. GOU NORF,	1 WILEUR STON	ET BALTIN	10 AV 16,	1287
•	Sta		31. Date filed (Month, Day, Year) 2 2006 32. Begistrar's Signaur	A PARTY OF THE PROPERTY OF THE PARTY OF THE	,	7	
	Regist	rar	WIRT A R LOSS	F			

			For State Registrar		State	of Ma	ırylan				lealth <i>Deatl</i>		lental Hy	giene Reg. No.	2006	159	88
			Decedent's Name	(First, Middle	, Last)					-		-	2. Date of Dea	ath		3. Time of D	Death
	Physici		Catherin	ne Eliz	zabeth To	ochte	rmar						Month May	Day 18	2006	10:30	ΔM^M
	/Medic Examir		4a. Facility Name (If				<u> </u>		4b. City	, Town, o	r Location	n of Death	ray		County of Dea		ZM1
			4306 Che	sapeak	e Court				Ba	ltimo	ore			P	Baltimo	re	
MAN	Funeral		5. Social Security Nu		6. Sex		(In yrs. I	ast birthday)		r 1 Year		er 24 Hrs.	8. Date of Birt	h	9. Bir	hplace (State or i	Foreign
7	Director		216-46-1		1□M 2∏F		91	Yrs.	MONITHS	Days	Hours	IVIII I.	12/03/	1914		rginia	
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H	ehow	5														10d. Inside City 1 ☐ Yes 2	
to	the M 28a-f	Director	MD 10e. Street and Num	Coun	ty		Ba	altimo		p Code							
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38	hours after turel', or ite	by	3 ☐ Widowed 4		If Yes,	Give r Dates:			☐ Yes	2 🔀 No	Specif	y:			Specify: TATh	ite	
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Elin	2 sho and is ma		19a. Informant's Nar	me/Relationsh	nip (Type, Print)			19b. Mailin	g Addres	s (Street	and Num	ber or Rura	il Route Numbe	r, City or	Town, State, 2	Zip Code)	
Ш.	- Lag 2				hterman,	Jr.		Access to the second			ane		ingsvil				57
A TH.	of Head		20a. Method of Dispo		3 □Removal fro	m State	20b. PI	ace of Dispo metery, cren	sition (Na natory or	me of other plac	ce)	С	ate	20c. Loc	ation - City or	Town, State	
1/ E	Peg ment ant: ury c		4 Donation				Oak	Lawn	Ceme	tery	. į	05/2	3/2006	Balt	imore,	Marylar	nd
4 Salt	permit. Peges Department of timportent: if Ite		21. Signature of Fun	eral Service L	icensee			22	. Name a	nd Addre	ss of Fac	17.				l Home,	
61	ă ∆ ⊆ ≅ ∂		10.	1.00	asaak	N		11	750	Bela	ir R	oad -	Kingsv	ille,			087
\circ		-	23a. Part1. Enter the shock, or heart	e disease, or of the failure. List of	complications that only one cause or	at caused t n each line	the death	. Do not ente	er the mo	de of dyin	ng, such a	is cardiac c	r respiratory ar	rest,		Approximate Interval Between	een
	Physician		Immediate Cause (F disease or condition	inal			De	hos	PA-	to.	N					Onset and De	ath
	/Medical		resulting in death)		Due 1	to (or as a	consequ	ence of).		-		ent				0,10	
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8760,	cate be execute physician and the burial-trans	dicai		-	d												
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Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certific death. •ctor: After this certificete hes been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent p in the past 12 m		1 Live	e birth 2	2 ☐ Fetal	death 3		regnancy	1 1			23	3d. Date of del Month	very Day Yea	ar
o.	the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∐Pre 9☐ Uni	egnantatt known	ime of de	ath 5∟	Other (s	pecify)	· ·					,	-
g.	hat the deby detac	F.	Part II. Other signific	ant conditio	ns contributing to	death but	t not resu	Iting in the ur	derhina	Cause and			23e Did to	bacco us	e contribute to	the cause of dea	nth?
<u>8</u>	signe signe				To continue and green			ang in mo u	donying .	sauso giv	on in an		1 🗆 Y		/	obably 4 Duni	
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ec ec	elaw hesi je 2 s	ig i											24a. Was a autop	an sy	24b. Were au	topsy findings ava completion of cau	ailable ise of
=	cete				·								perfor		death?	2 🗆 No	
<u>Sit</u>	ilcien: Th certificete rector, pag	Be	25. Was case referre examiner?	_	Hospital:					1 0+			Check only or				
of o	Phys this al dir	2	1 ☐ Yes 2 ☐ N 27. Manner of Death	Ю	11			R/Outpatien			7 🗆 .		ne 5 🖳 Resid			ufy)	
n n	ding Physicien: The lav n. After this certificete hes funeral director, page 2	io i	1 Natural	5 Pending	(Mc	te of Injury o <i>nth</i> , <i>Day</i>	Year)	28b. Time of Injury	м	28c. Injun Worl			28d. Describe h	ow injury	occurred		
Sic	ttendii death. ctor: A y the fu	Certification:	2 ☐ Accident 3 ☐ Suicide	investig	ot be	oo of Injur	n. At hor	no form star			Yes 2		194 Legation /C	**************************************	M		
Ž	or A after Direct in by	it.	4 Homicide	determi	ned 286. Pla bui	ilding, etc.	. (Specify	ne, farm, stre	et, racior	y, office		1	City or Tow	reet and n, State)	Number or Hu	ral Route Numbe	¥r,
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu		29a. Certifier	Cartifuin	g Physician: To t	the best of	f my kaan	vledge dest	0001107	at the si-	na data -	and class	and does to the			-4-4-4	
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	o the ithin; o the smple	Me	29b. Signature and ti	itle of certifier					29	c. License	e number		1 2	9d. Date	signed (Montl	Day, Year)	
	F \$ F 8		()	1 11	> AT	tendi	Na.	ucd.		7	171	18		Ma			
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	10		30. Name and address		who completed ca			ZJaj (Type, I	rint)	Ja.	lan	N R)A)	202	10-		
	Sta	to.	31. Date filed (Month	200		- 4					, , , , ,	,,,,,,		~ (C	10		
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5-03301		Please Type or Print in Black Indelit	ble Ink			
ary E. Thibault		State of Maryland / Department of Health and N	Mental Hy	giene		
		For State Certificate of Death		Reg	. No.	16 1598
Physician		. Decedent's Name (First, Middle,Last)	2	2. Date of Death Month	Day Year	3. Time of Death
Medical Examine	er	MARY E. THIBAULT		May 16, 20	06	1155 hrs
ar albahating	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County of Death	
	ш	7517 Old Coaling Road, Apartment 2 Harmans			Anne Arundel	
Funeral	Ę	Coolar Goodinty Harrison	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bir Foreig	
Director	- [,	011-46-3020 1 M 2 x F 45 Yrs. Months Days	Hours Min.	11/12/	0	MASS.
	_	Usual Residence of Decedent		1 1/ 1~/	1700 1	
any	7	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
*	_	N.H. ROCKINGHAM SALEM				1 Yes 2 X No
Maryland 28a-f show d at once.	읽는	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Cou	intry?
e lie	Director	03079			USA	
ith th		2 FMFLEO LANF 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar	nic Origin? (Spe	ecify Yes or No-		rican Indian, Black,
ath w	ᇒᅵ	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, M	Mexican, Puerto F	Rican, etc.)	White, etc.	
er de		1 Yes 2 X No 3X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No s,	specify:		Specify:	VHITE
irs aft ural'	⋛├	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation	n (Give kind of wo		16b. Kind of Business/	'Industry
2 hou "nat	흵누	Elementary/Secondary (0-12) College (1-4 or 5+)	O NOT use retire	ed)		
36 nin 7 than dical	쁿	2 YEARS HOMEMAKER			OWN HOME	
15-0036 filed within 72 hours af flygiene. I other than "natural t, the Medical Examin	Completed		.Mother's Name ((First, Middle, M.		
	Be	LEONARD B. ALBIS	BETTY	ANN DEUN	ALTNG	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an				e, Zıp Code)
and 2 should be fi ealth and Mental I tem 27 is marked traumatic event,	-1	ANN F. THIBAULT/MOTHER-IN-LAW 11 BERRY LANE	GREEN	LAND. N.	н. 03840	
e, N I and Health Health item		20a. Method of Disposition 20b. Place of Disposition (Name of cemet		Date	20c. Location - City or	r Town, State
		1 Burial 2 X Cremation 3 Removal from State crematory or other place) LINWOOD CREMATORY	5/2	3/2006	HAVERHILL	MASS
Haltimore, errit Pages I ar epartment of Her mportant: If ite njury or other tr	+	4 Donation 5 Other Specify: DINWOOD CREMATOR1 21. Signature of Funeral Service Licensee 22. Name and Address of				
Ealtimo errit Page epartment of mportant: njury or oth		8521 LOCH R	7111	E JOHNSO	ON FUNERAL	HOME, P.A. 1286
100	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc				Approximate Interval
Physician /Medical		failure. List only one cause on each line.				Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) a. Exsanguination due to Vascula Due to (or as a consequence of):	ar Malfo	ruation		+
	1	h				
	Ӹ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	틝	cause. Enter Underlying Cause (Disease or injury that initiated				
sit id	Examine	events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transi	Eg	d. #00 807D am c053	7 7/10/0	V 11-		
		X UNPENDED AMENDED Item #23a&27Per ME G857	/ //19/0	o Jn		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring.		IF FEMALE: 23b. Was decedent pregnant in the 25c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnar	OCV	23d. Date of deliver Month	ry Day Year
68 certif nding ise as	ä	past 12 months? 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify)			in a constant	
30x Jeath e atte	ysi	1 Yes 2 No 9 V Unknown 9 Unknown			1	
Division of Vital Records, P.O. Button the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached if		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
P.(ompleted by			1 Yes	2 No 3 Pro	obably 4 🗸 Unknown
ds, equire een si	š			24a. Was a		utopsy findings available
law r has b	힑			autops perfori	med? death?	completion of cause of
Rec The icate	힝			1 ✓ Yes 2	2 No 1 Y	'es 2 No
tal	Be	evaminer?	of Death (Check of Death (Chec			
this all din	힏	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA			Residence 6 🗸 Othe	er: Scene
n of ing P		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury 28c. Injury 1 Yes	es 2 No	Zou. Describe n	ow injury occurred	
ion Itend Teath. Tor:	at	2 Accident Investigation				
ViS or Au fifter of Direct in by	읦	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office buil	ildıng, etc.	28f. Location (S or Town, St		tural Route Number, City
eral pital	Certification:	4 Homicide determined (Specify)	Į.			
Hos 24 h	a	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only)	e and place, and	due to the cause	e(s) and manner as sta	arted.
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d		it the time, date a		
F×Fō	ž	29b Signature and title of certifier 29c. License r			29d. Date signed (M	onth, Day, Year)
		(al-11102546, O.C.M.	I.E.		May 17, 2006	
7		30. Name and address of person who completed cause of death (Item 23a)				
0		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 212	201		
Sta	ate	31. Date filed (Month, Day, Year) MAY 2 2 2006 32. Rigistrar's Signature				
Regist		MAY 2 2 2006 Mayor St. Sporter				

ORIGINAL

			1 - For State Registrar	10000	of Marylar	•	artment tificate					Reg	ene . No	06	159	90
	Physicia	an	1. Decedent's Name (First, Middle								2. Date of I		Day	Year	3. Time of I	Death PM
,	/Medic Examin		Philip J. Ve 4a. Facility Name (If not institution Bayview Hosp	give street and nu					Location o	of Death	May 1	0 .	4c. County	of Death	8:23	P
+	Funeral	4	Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	1 Year	If Under		8. Date of E	Birth		9. Birthp	lace (State or	Foreign
	Director		216-20-5526	1 XM 2 ☐ F	80	Yrs.	Months	Days	Hours	Min.	July	28	1925	Coun Mo		
	and land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside Cit	y Limits
	death with the Maryland ma 23a or 28a-f ehow r must be to dilled at	tor	Md. Balt	imore	D	undalk									1 🗌 Yes	2 X No
	or 284	Olrec	10e. Street and Number		· '		10f. Zip (Code				100	. Citizen of V	What Coun	try?	
	ath w	ral	7913 St. Gre			10		2122		-0.40			USA			
	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. The file file at 28 or 28s-1 show file marked other then "naturel", or items 28s or 28s-1 show other traumatic event, the Mudical Examinar must be inclifted at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	Armed F	2 No		Was Decede fYes, speci 1 ☐ Yes 2				cify Yes or t Rican, etc.)	NO-	Blac	e - Americ ck, White, c v: Whi	etc.	
2-0030	natur	Completed	15. Decedent (Specify only highes	's Education	1	16a. Deced	dent's Usual	Occupa k done d	ation Juring most	t of workin	na .	16	ib. Kind of Bu	usiness/Ind	dustry	
7	hen .	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. l	kind of work				,		QL	1		
7 7	e filed within al Hygiene. I other then " vent, the Me	CO	12 yrs. 17. Father's Name (First, Middle, I	Last)	yrs.		Timek	eepe		er's Name	(First, Mida	ile, Ma	Stee.			
ylalla	fental rked c	To Be	Frank Ventur						Ida	Libe	ertini					
9	nd 2 should be alth and Mental 27 ie marked (r traumatic ev		19a. Informant's Name/Relationsh Hennrietta		wife		-						ity or Town,		Code)	
บิ	os 1 ar		20a. Method of Disposition		20b.	Place of Dispo cemetery, cren	sition (Name	e of her place	9)		ate	20	c. Location -	City or To	wn, State	
	Page nent c ant: if ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State Me	adowrid	lge Me	m. I	Park '	May 2	22 , 2006	E	Elkrid	ge Md	•	
Dalillo	permit. Pages Department of I Important: If ite eny injury or of		21. Signature of Funeral Service of the Service of	C. Con	rnell	71	10 So	ller	rs Po	int F	ne Of Rd. 21	222	2			
	icate be executed Medical Examiner bhysician and streamst transit	edical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to	(or as a consector as	quence of):	1_		V	Scar			,		Approximate Interval Betwo	veen
DOY.	the death certificate y the attending phys ched for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregn birth 2 □ Feti nant at time of ∈ nown	al death 3	Ectopic pre Other <i>(spe</i>					-	23d. Dat Mo	te of delive nth		ear
ecords, r	The law requires that the de ite has been signed by the a page 2 should be detached	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying ca	use give	en in Part I.				cco use cont		e cause of deal	
משב	The larate has	Completed				*					24a. Wt au pe 1 Yes	topsy rforme	d?	prior to con death?	osy findings a npletion of ca 2 No	vailable iuse of
N 11.0	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:		/		Othe	· ·		(Check only					
5 5	ing Phys .r After this funeral di	tlon: To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date		28b. Time of Injury		Bc. Injury Work	4 🗀 140	2			ce 6 □Oth		()	
DIVISION		Certification:	2 Accident INVESTIG 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Plac	e of Injury - At h	nome, farm, str					18f. Location City or 7	(Stre	et and Numb State)	er or Rura	l Route Numb	оө <i>г</i> ,
	To the Hospital or within 24 hours after To the Funeral Dir con pletely filted in	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To th Examiner: On the I and man	e best of my kn casis of examin nner stated.	owledge, death ation and/or in	n occurred a vestigation,	it the tim in my op	e, date an pinion, deat	d place, a	and due to the	ne cau e, date	se(s) and ma	inner as st and due to	ated. the cause(s)	
)	withir To th	Me	29b. Signature and title of certified	1 6	2 V	ws	29c.	_	number	14		290	I. Date signed			,
1	2		30. Na 🕝 d address of per on	who impleted cau	se of death (Ite	_		0	Yul		S		t ver	My	200(2007	J6
Section 1	Sta Regist		31. Date filed (Month, Day, Year)	2006	Registrar's Sign	ature	Market !									-

			1 - State Registrar	of Marylan		rtment of H tificate of L		Re	eg. No. 4 UU	5 15991
	Physicia	an	Decedent's Name (First, Middle, Last) Donna Lee Watson					2. Date of Deat Month	Day Year	3. Time of Death 1:05 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Deal	May 20, 2	4c. County of De	
			2621 Wycliffe Road 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	Baltimore If Under 1 Year	If Under 24 Hrs.	9 Date of Righ	Baltim	ore inthplace (State or Foreign
	Funeral Director		212-46-8457		Yrs.	Months Days	Hours Min.	September	Year	Vary land
	and m		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-f eh	ctor	Maryland Baltimore		Baltimo	re				1 ☐ Yes 2√☐ No
	with the	Funerai Directo	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What (Country?
	me 23	nerai	2621 Wycliffe Road 11. Marital Status 12. Was 1	Decedent Ever in U.	.S. 13. V	21234 Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	USA 14. Race - An	
20	or ite	by Fur	1 Never Married 2 Married 1 Yes	Forces? es 2 X No . Give		res, specify Cuba □ Yes 2)(No	n, mexican, Puen Specify:	o Hican, etc.)	SpecifyWhi	
2-003e	in 72 hours after deeth with the Maryland "naturel", or tteme 23a or 28a-f ehow adical Examinar must be notified at	ted b	15. Decedent's Education	or Dates:	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busines	s/Industry
212	within 7 iene. then "n the Medi	Completed	(Specify only highest grade completed [Specify only highest grade completed] Elementary/Secondary (0-12) College	e <i>d)</i> je (1-4or 5+)	1	kind of work done of NOT use retired		rking	Office	
7 0	filed v Hygie other t	0	17. Father's Name (First, Middle, Last)		AGIIITI	strative Se		ne (First, Middle, M		
ylan	should be ind Mental marked umatic ev	To B	Paul Seibert Miller				Sylvia De	Rose Heilde	rburg	
Mar	nd 2 shoulth and 27 ie m		19a. Informant's Name/Relationship (Type, Print) David Lee Watson, Sr./Husban	d		-		_{iral Route Number,} ore Marylan	. City or Town, State, nd 21234	Zip Code)
e,	Hea Hea	- 6	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other plac	-		20c. Location - City of	or Town, State
E	permit. Pages Department of Important: If If eny injury or o		¹XXBurial 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	Ga	rdens of	Faith	5/23	/06 B	Baltimore Man	ryland
n n	Depar Impor eny in		21. Signature of Funeral Service Licensee Chr	istina L. H	ilton 22	Name and Address eonard J. F	Ruck, Inc.	ltimore Mar	yland 21214	1
ı			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death						Approximate Interval Between
	Physician /Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	laulo	N	your	udi	1 Du	(art	nset and Death
	Examiner	1	Due	to (or as a conseq	uence of):	1	Sem	7 10	· sur	ulars
-	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a conseq	uence of):					8
_	be executed siclen and burial-transit	Examiner	triat initiated events	to (or as a conseq	uence of):					
9/90	at ye de	dicail	d							
õ	eath certifica attending pl		IF FEMALE: 23c. If yes	outcome of pregna	incv				23d. Date of d	olivon
. Box	death e atter	Physician/Me	in the past 12 months?	ve birth 2 ☐ Feta regnant at time of d nknown	I death 3	Ectopic pregnancy Other (specify)			Month	Day Year
л О	hat the de id by the a detached i		9 Unknown Part II. Other significant conditions contributing		ulting in the se	aderlying cause give	on in Part I	23e Did toh	nacco use contribute	to the cause of death?
rds,	law requires that the es been signed by th 2 should be detache	d by	Churc Ob	twee	it (ulun	7 dis			Probably 4 Unknown
Vital Hecords,	law rec es bee 2 shou	Completed	Their plum	Vas	alv	· d 3	case	24a. Was ar	n 24b. Were a	autopsy findings available ocompletion of cause of
T ā	ician: The lav certificete hes rector, page 2 (Kidney.	des	in	/		perform 1 ☐ Yes 2	ned? death?	
	Attending Physician: r death. ector: After this certifice by the funeral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 Was Hospital:	☐Inpatient 2☐	ER/Outpatien	t 3 DOA Othe	\r-	th (Check only one	nce 6 Other (Sp	ecify)
n o	ding Ph h. After th funeral		27. Manner Teath 1 Natural 5 Pending	ate of Injury Month, Day Year)	28b. Time of Injury	28c. injury Work	at	28d. Describe ho		,,
Division	of or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. P	lace of Injury - At he	ome, farm, stre		fes 2 □No		reet and Number or F	Rural Route Number,
Š		Certi	4 Homicide	uilding, etc. (Specif	y)			City or Town	, State)	
	To the Hospital c within 24 hours at To the Funerel D completely filled in	edicai	29a. Certifier 1 Certifying Physician: To (Check only one) 2 Medical Examiner: On the one)	the best of my kno ne basis of examina nanner stated.	wiedge, death tion and/or inv	occurred at the time time of the stigation, in my or	ne, date and place pinion, death occu	e, and due to the ca stred at the time, da	tuse(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of contifier			29c. License	number	25	9d. Date signed (Mor	nth, Day, Year)
•	<		1000000	LE MATE	17	100	835	8	MAGZ	2 2006
5	/ 1		30. Name and address of person who completed	ause of death (Item	1 23a) (Type, I	Print) 84	03 H	ART	RU1-11-11	1021231
Ì	Sta			2. Registrar's Signa	iture	200	H.	pa 4	1-10-11	4111
A	Registr	ar	MAY 2. 2. 2006 L	8 39.40 0 B	AS ASSE	W-64-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** -OBERT 1040 AM L WHITE 10 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Maryland Madical Conker 6. Sex 7. Age (In yrs. last birthday) If Uno Bo Stimore Mersity Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-28-19. 7. Age (In yrs. last birthday) If Under 1 Months Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10 M 2□F 217-60-4383 MAR Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event. If a Madical Examination mutal to instilled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No ALTIMORE Director MD, 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21207 To Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WHITE VIRGINIA KOBERT KOSS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANTOINE WHITE BALTO. MD. 21207 1745 CHAMPLAIN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) TY CEMETERY OS-20-06 BALTO. MD.
22. Name and Address of Cility PHILLIP A. WEATHER PORD FUNDRER SERVICE. BALTO. MD. 21213 2431 E. OLIVER 51. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ~1.5 years **Physician** prain cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Box 68760; Physician/Medical IF FEMALE . If yes, outcome of pregnancy

1 Live birth 2 Fetaf death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Sic 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) to Funeral Direct 4 Homicide 25s Cartifica 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Garies &

S. Greene

32. Registrar's Signature

10,2000

Name and address of person who impleted cause of death (Item 23a) (Type, Print)

Any S. Rugsted mes 31. Date Med (Month, Day, Vear) MAY 2 2 2006 06-03323 1U

Please Type or Print in Black Indelible Ink

	e Type of Time III Black indensie ink
State of Maryla	and / Department of Health and Mental Hygiene

NK UNK	State of Maryland / Department 1- For State Certificate	of Doath	2006 1599
Physician/	Registrar	110	Day Year
ledical Examiner	HARON DANIEL WILSO	May 16, 20 4b. City, Town, or Location of Death	
	Facility Name (if not institution, give street and number) University of Maryland Shock Trauma C	Baltimore	N/A
Funeral Director		If Under 1 Year If Under 24Hrs. 8. Date of Birt Months Days Hours Min. August	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) HARGIAND
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation	10d. Inside City Limits
Maryland 28a-f show d at once. ector	MARYLAND NIA BALTIM	CEE 10f, Zip Code 10	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	150 S. Hiltan Street	21229	G. Citizen of What Country?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
s after der ral", or i niner mu by Fu	1 Yes 2 No 3 Widowed 4 Divorced of Pales:	Yes 2 No specify:	Specify: African AMERICAN
hours a 'natura Exami	15 Decedent's Education (Specify only highest grade completed) 16a Dece	dent's Usual Occupation (Give kind of work done g most of working life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 hour Hygiene I other than "natu the Medical Exar	12 ⁴ h	Andy-MAN	OWN Pusiness
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica To Be Comple	The state of the s	18. Mother's Name (First, Middle, N	Maiden Surname)
2121; hould be fill and Mental H is marked ritic event,	19a, Informant's Name/Relationship (Type, Print) 19b. Ma	illing Address (Street and Number or Rural Route Num	1
一 日昔日声	20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery, Date	20c. Location - City or Town, State
2 ≤ 5 = 2	4 Donation 5 Other Specify:	memorial Park May 24, 2006	Woodhaw Maryland
Baltimo permit Page Department of Important: injury or ott	21. Signature of Funeral Service Licensee	2, Name and Address of Facility JANEY M. WALLAGE FUNER 3:105 W. FRANKLIN St. BA	M Service / 2/229
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. Listurity one cause on each line.	er the mode of dying, such as cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and
#Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a Multiple Gunshot Wounds Due to (or as a consequence of):		Death
	Sequentially list conditions, b.		
ed nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		
sici	UNPENDED AMENDED		
Ox 6876 ath certificat attending ph or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery Month Day Year
P.O. Bases that the degree detached for both properties of the period of the period for the peri		and dilidonying daddo giron in rate.	bacco use contribute to the cause of death?
rds, P.O. requires that the been signed by hould be detach lefted by P.		1Yes	an 24b Were autopsy findings available
Records, The law requires freate has been sig , page 2 should be		autop perfor 1 ✔ Yes	sy prior to completion of cause of death?
tal Rections: The certificate rector, page	25. Was case referred to medical	26.Place of Death (Check only one)	
f Vitt	1 Yes 2 No		Residence 6 Other.
ision of Attending Ph. r death. rector: After ti by the funeral	1 Natural 5 Pending FOUND: Pounding May 16, 2006 2214 hrs	1 Yes 2 ✓ No Subject sho	
Division of Vital Records, spital or Attending Physician: The law requir nours after death. Ineral Director: After this certificate has been signed in by the funeral director, page 2 should the contification. To Re Complete Contributed.	2 Accident Investigation 3 Suicide 6 Could not be determined Coeffy Local Street	street, factory, office building, etc. 28f. Location (S or Town, S	Street and Number or Rural Route Number, City tate) of Eagle Street , Baltimore, MD
To the Hospi within 24 hou To the Funer completely fil	798. Cellie	occurred at the time, date and place, and due to the caus	e(s) and manner as started.
To To Con	1/// // / / / / / / / / / / / / / / / /	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 17, 2006
	30 Name and address of person who completed cause of death (Item 23a)	U. U.IVI. E.	17, 2000
5	Laron Locke MD. Assistant Medical Examiner 111 Pe	enn Street, Baltimore, MD 21201	
Stat Registra		ade	
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			110030 1	State of Maryland	d / Dens	rtment of H	lealth and	Mental Hy	niene		
			_ State	State of Maryland		tificate of		Wichtarry	Reg. No.	111111	15996
	k		Registrar 1. Decedent's Name (First, Middle, Last)			imodio or		2. Date of De	ath		3. Time of Death
	Physicia		Jacqueline William	ıs				May 3,	2006	Yeer	12:55 p ^M
	/Medic Examin		4a. Fecility Name (If not institution, give st			4b. City, Town, o	r Location of Dea		_	County of Deet	
			3144 Yorkway			Dunda1k			_B	altimor	:e
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, De		00	hplace (State or Foreign untry)
	Director		18/-14-0961	81	Yrs.			Oct 17	, 192	24 Peni	nsylvania
	and and	1	Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary -f • ho	ō	MD Baltimore	D111	ndalk						1 ☐ Yes 2x No
	7 28e	Director	10e. Street and Number	, , ,	ITTT	10f. Zip Code			10g. Citi	zen of What Co	untry?
	death with the Maryland rms 23e or 28e-f ehow r must be notified at	a D	3144 Yorkway			21222			USA		
	ems er m	Funeral	11. Iviginal Glatos	Was Decedent Ever in U.S Armed Forces?	S. 13. \	Was Decedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, White	
õ	or It	by FL	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1□Yes 2점No	Specify:			Specify:	
31215-003b	within 72 hours after ene. than *natural', or ite ta Mudical Era alica	d be	3 Widowed 4 Divorced	Year or Dates:	16a Decer	ient's Usual Occup	ation		16b. Kir	Whi nd of Business/	
ς C	in 72 n •ns	Completed	(Specify only highest grade	completed)	(Give life.	kind of work done OO NOT use retired	during most of we	orking			,
7 7	d with giene.	mo.	Elementary/Secondary (0-12) 12 n	College (1-4or 5+)	Hous	sewife			Ow	n Home	
	be filed within 72 hours after death with the Marylan Hygiene. I Hygiene. I other than 'natural', or Items 23a or 28e-f show event, It a Medical Eraphrer must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden	Sumame)	
<u> a</u>	should b nd Menta marked umatic e	10 [Daniel P. Gracey					Gladys P			
Maryland	C 0 = =		19a. Informant's Name/Relationship (Typ			ng Address (Street				Town, State, 2	Zip Code)
	of Health itam 27 other tr	-	Daniel Williams/sp			Yorkway	Dundalk	, MD 212		cation - City or	Town State
0			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	1 00	emetery, crer	natory or other pla	ce)	Date	200. 20	cation - City of	Town, State
Baltimore,	Department Department Important:		*4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		20	. Name and Addre	es of Facility				
g R	permit. Page Department Important: Il any injury o		Ronald 9. Ma	ide, Director	S	tate Anai	tomy Boar	rd 655 W	. Bal	ltimore	Street
o	AT.		23a. Pert1. Enter the disease, or complic	ations that caused the death		altimore, er the mode of dyir			rrest,		Approximate
	Physician		shock, or heart failure. List only one Immediate Cause (Final	a cause on each line.		. aca Nina	12 - Pa	10.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	0/14/400	Ital 14	134			Tyear
П	Examiner		Sequentially list conditions b.								
	D =	iner	s quentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):						
	and -trans	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):				_		
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	death e atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐Fetal 4☐Pregnant at time of de		Ectopic pregnancy Other (specify)	/			Month	Day Year
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s,	8 50	by F	Part II. Other significant conditions cont	inbuting to death but not resu	ulting in the u	nderlying cause giv	en in Part I.				the cause of death?
ord	w require been si should I	Completed						''	Yes 228		obably 4 Unknown
ec	has b	nple						24a. Was	DSV	prior to d	topsy findings available completion of cause of
H								1 Yes	ormed? 2 No	1 Yes	2 [₹] No
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	Phys r this ral di	1: To	1 Yes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Inju	y at	Home 5X Res 28d. Describe			city)
O	th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M 1	rk? Yes 2 ⊡No				
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	s afte	Certification:	4 El Homeso	Building, Sto. (Specify	N/A			0.1, 0.7		,	
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical ((Check only 2 Madical Examin	sician: To the best of my known ar: On the basis of examinat	wledge, deat	h occurred at the tri	me, date and place	ce, and due to the	cause(s) date and	and manner as	s stated. to the cause(s)
	the thin 24 the F	Medi	one) 29b. Signature and title of cortified	and manner stated.		29c. Licens				e signed (Monti	``
•	To To	-	230. Signature and title of certifier	209			2232			5 / 06	., 50,, 100/
			30. Name and address of person who cor	moleted cause of death (Item	23a) (Tuno					7/00	
			Scott A Feo Coc		0 0	ve. B	altima	e MD	21	222	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		. A. P. M.					
	Regist		MAY 2 2 2006	18 18 AS. 1 S. S.	100	C.C.					

			For State Registrar	S	tate of	Maryl	and / De				ealth a	ind M	ental H	ygiene Reg. No	20	06	15995
	Physici /Medic	an al	1. Decedent's Name (First, Midd HENRY O. ADEI	MAN]	2. Date of D Month MAY 5,	200		Year	3. Time of Death
	Examin	E1	4a. Facility Name (If not institution BETHESDA HEAL)	. 3	REHA	BILAT]	City, Tov	ESDA	Location o		O Date of D	МО	. County o	MERY_	In Contract Contract
- 20	Funeral Director		5. Social Security Number 138-10-8731 Usual Residence of Decedent		2 🗆 F	92	yrs. last birthd Yrs	Mo		ays	Hours	Min.	8. Date of B (Month, L IARCH	15, 1	914	9. Binnp Coun NE	lace (State or Foreign try) W JERSEY
	a-f show	ctor	MD MONTO				. City, Town o		on							1	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	ath with the 23a or 28	Funeral Director	10e. Street and Number 3620 LITTLEDALE	ROAL	, APT	304	ł		of. Zip Co 20895					10g. Ci			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show minourant: in Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Examinar must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce	ried	Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 ₁ ∏No e	n U.S.	If Yes	Deceden s, specify Yes 2	Cubar	spanic Origin, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	lo-		, White,	an Indian, etc. ite
21215-0036	within 72 ho plene. r than "natur the Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12) 12			-4or 5+)	(G	ive kind	VOT use r	done di	urina most	of workin	ng		SHIN		dustry GLASS
Maryland 2	uld be filed Aental Hyg rked other	To Be C	17. Father's Name (First, Middle LOUIS ADELN								18. Mothe		(First, Middi				
, Mary	and 2 sho eaith and P n 27 is me		19a. Informant's Name/Relation BARBARA PRICE-			- 1	300	3 WI	HITE	PIN	nd Numbe	IVE	Route Num MONRO	VIA,	MD 2	21770)
Baltimore,	Pages 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify)	oval from S	State	b. Place of Di cemetery, IUDEAN	MEM.	ry or othe GAF	r piace RDEN	NS M	AY 7	ate , 2006	0	LNEY,	MD	
Ball	Depart Import eny in		21. Signature of Funeral Service	$?$ \angle	tou	lem	yer	1091	l ROC	CKV1	[LLE	PIKE	ROCK	VILL			I, INC. 552
68760,	Physician /Medical Examiner Physician and	Ilcai Examiner	23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c d	Due to (control of ALZH	or as a con or as a con or as a con E IMER	sequence of):	or t	Head	X	di	Sean fail	ne				Interval Between Onset and Death
.O. Box 6	that the death certifical led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c		rth 2 🗍 I ant at time	Fetal death		opic pregr ner (s <i>peci</i>			-			23d. Date Mon		ry Day Year
σ.	w requires that the been signed by the should be detached	Ď	Part II. Other significant condit RENAL INSUFFI		_	ath but not	resulting in th	ne under	lying caus	se give	n in Part I.						e cause of death? ably 4 DUnknown
Records	The law ate has b page 2 sl	Completed	LUNG CANCER S	TATUS	POST	SURG	ERY						per	s an opsy formed? 2 🌠 No	pr de	fere autorior to coreath?	osy findings available inpletion of cause of
of Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medic examiner?	_	pital:					Othe	61		Check only				
on of	ding P. After fune	ıtlon: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pend 2 ☐ Accident inves		1 🔲 li 28a. Date o (Monti		2 ER/Outpa 28b. Tim Inju	ne of	3□ DOA 28c. M	Injury	140.10	2	ne 5 🗌 Rei 8d. Describe				′)
Division	ital or Attenders after death rai Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could	not be	28e. Place buildir	of Injury - and of Injury - an	At home, farm pecify)	, street,	factory, o	ffice		2		(Street arown, State		r or Rura	Route Number,
	Hosp 4 hou Fune ely fil	edicai	(Check only 2 Medics one)	Examine	ian: To the : On the ba and mann	isis of exar	knowledge, d mination and/d	leath occ or investi	igation, in	ту ор	inion, deat	d place, a th occurre	and due to the	, date an	d place, a	nd due to	the cause(s)
•	To the vithin 2 To the complet	×	29b. Signature and title of cert	The state of the s	edd		M) .		536	number 91				te signed		Day, Year)
	,		30. Name and address of person AJAY REDDY, MD				(Item 23a) (Ty Y BOUL			ЕТН	ESDA.	MD	20817				
4h 4h	Sta Regist		31. Date filed (Month, Day, Yea MAY 0	-)	32. R	egistrar's S					;						

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			1 - For State Registrar		State of M	laryland		artment <i>tificate</i>			lental Hy	gien Reg. No	2000	15996
	Physici	an	1. Decedent's Name (First, RUTH S.	Middle, Las ATK	INS						2. Date of De Month	ath Da		
	/Medic Examin		4a. Facility Name (If not ins REEDERS NU)			Town, or Lo	ocation of Death	MAY		2006 County of De WASHING	ath
	Funeral Director		5. Social Security Number 235-44-7402	6. S		ge (In yrs. lasi 76	t birthday) Yrs.	If Under Months		f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De 5/22/			rthplace (State or Foreign ountry) T VIRGINIA
	and w		Usual Residence of Decede			10c. City, T	own or Lo	cation						10d. Inside City Limits
	Maryi a-f sho	ţo	WV BE	RKELE	Υ		MARTI	NSBUF	RG					1 □ Yes 2 □ X No
	th with the 23a or 28	Funeral Director	10e. Street and Number 279 BOTANY	DRIVE				10f. Zip	Code 25401			_	tizen of What C	country?
0500-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at ODGe.	Š	11. Marital Status 1 □ Never Married 2 □ 3 ☑ Widowed 4 □ Div		12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	1	Vas Deced Yes, spec		anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify:	
0-01717	d within 72 ho jene. r than "natur rhe Medical	Completed	15. De (Specify only Elementary/Secondary (C		lucation de completed) College (1-4or		(Give life. L	lent's Usua kind of wor DO NOT us CICAL	l Decupation de de l'estimation de l'estimatio	on ing most of work	ing		Gind of Busines: & P TEL COMP	EPHÓNE
land,	uld be filed Aental Hyg rked othe tlc event,	To Be C	17. Father's Name (First, M LINCOLN EL						18	3. Mother's Name MARY D	<i>(First, Middle</i> ENA BAU		n Sumame)	
, Mary	and 2 shoralth and N		19a. Informant's Name/Rel MELISSA ALL							Number or Rura E, MART				Zip Code)
More	Pages 1 and of He toth it if item try or oth		20a. Method of Disposition 1 Derivation 2 ☐ Cremi 1 Donation 5 ☐ Ott			20b. Plac MID01	e of Dispos	sition (Nam 1430) NTC	e of her place)	MAY 10, 2	006		ocation - City o LEWAY, W	
baltimo	permit. Departn Imports any inju		21. Signature of Funeral Se		Biown		22 B	ROWN 327 W.	Address FUNE KING	TAL HOME	P O.	ВОХ	821, 5402,	
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	اليطر	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	Due to (or as	s a consequen	ce of):	umo	سكسو			-		fu do
09/00	ficate be executed g physician and is the burial-transit	edical E		l	d									
.O. BOX 0	certi nding se a	Physician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pre Other (spe					23d. Date of de Month	olivery Day Year
ras, r	law requires that the death as been signed by the atter 2 should be detached for u	by	Part II. Other significant co		ontributing to death I		ng in the un	derlying ca	iuse given i	in Part I.				o the cause of death?
I Records	a sc	Completed						-					prior to death?	utopsy findings available completion of cause of
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to mexaminer?	edical	Hospital:	-5-			011	6. Place of Death				
0	ding Phys n. After this funeral di	n: To	1 Yes 2 No 27. Manner of Death	and and	28a. Date of Inju		Outpatiens b. Time of Injury		Bc. Injury at Work?	4 Dursing Hor	ne 5∐Resi 28d. Describe I			ecify)
IVISION	r Attendin ter death. irector: Af irector: Af	Certification:	2 ☐ Accident iii 3 ☐ Suicide 6 ☐ 0	ending ivestigation ould not be etermined	28e. Place of In			М	1 🗌 Yes	2 □ No	28f. Location (S City or Tox	Street ar	nd Number or R	ural Route Number,
ב	To the Hospital or Attending Physician: The Caythin 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Cer	29a. Certifier 1 Cec (Check only 2 Me	rtifying Ph dicel Exen	ysician: To the best niner: On the basis of and manner si	of examination	dge, death	occurred a	it the time, in my opini	date and place, a	and due to the ed at the time,	cause(s date an) and manner a d place, and du	s stated. e to the cause(s)
	To the To the To the Comple	Med	29b. Signature and title of c	ertifier	and mainer s	iatou.		29c.	License n	umber			te signed (Mon	
0	1		-	tot	MO			D	(29)	ડ (લ્		MA	48,7	ے د سے
	5		30. Name and address of p	TTA.	340 MILL	ST., H	AGERS		MARY	LAND 21	740 3	01-7	739-7100)
	Sta Registr		31. Date filed (Month, Day,	1 0 20	32 Regist	rar's Signature	Pos	Mad						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		epartmer Certifica				Re	g. No.	006	159	97	
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year								3. Time of E)eath			
7	/Medi	cal	4a. Facility Name (If not institution, give	ctreet and number)	うりは	M5	Town or	Location of De		MAY	03	2006 inty of Deatl	1850	M	
	Examir	ner	Anne Arundel Med		2r	1 '	nnapo		atri			e Aru			
	Funeral	19,20	5. Social Security Number 6. S.	ex 7. Age	e (In yrs. last birt	hday) If Unde	r 1 Year	If Under 24 H	irs. 8	Date of Birth (Month, Day,		9. Birth	nplace (State or	Foreign	
×.	Director		149-30-7477	□ M 208€	77	rs. Months	Days	Hours M	'n. I	Dec. 26	, 192	8 New	York		
60	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					<u> </u>		10d. Inside City	Limits	
	f sho	ō	MD. Prince	Coorges			wie						Marian Yes a		
	the r 28a	Funeral Director	10e. Street and Number	deorges	I		p Code			10	g. Citizen	of What Co	untry?		
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	ems ?	iner	11. Maritaí Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Dece	dent of Hi	spanic Origin? n, Mexican, Pu	(Specif	y Yes or No-	14. F	Race - Amer Black, White			
36	or le	by Fu	1 Never Married 2 Marned	1 ☐ Yes 2 🔯 N If Yes, Give	No	1 ☐ Yes		Specify:	0.10.11	211, 010.7		city:Whi			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f ehow early laury or other traumatic event, the Medical Exam carminal te multiled at Once.	d b	3 XWidowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	162	Decedent's Usu	of Occupa	tion.							
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212	d with	mo:	Elementary/Secondary (0-12)	College (1-4or 5		elephon	e ope	rator		(Commu	nunications			
פר	e file al Hyg other	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (F	irst, Middle, M	laiden Sun	n Sumame)			
<u>la</u> i	Menta Menta arked	To	Unknown					Unknow	า						
Maryland	2 sho and Is ma		19a. Informant's Name/Relationship (1		Î	Mailing Addres									
6, 1	t and tealth im 27		Elizabeth Dodgso	n – daught		23 Anche			, Ar.						
Baltimore,	ages or of h		1 ☐ Burial 2 反 Cremation 3 ☐			Disposition (Na			-05-	.06		on - City or 1			
풀	it. Partmen		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Septice Lines		Metrop	olitan (dria,	VA.		
Ba	Depa Impo eny l			Tose	all					l Funer			20715		
	*		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician /Medical Examiner	0	Immediate Cause (Final										Onset and De		
			disease or condition resulting in death)	1):	as C						2015	7			
			Sequentially list conditions	b	link	in								,	
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Box (that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy								23d.	Date of deliv	elivery		
	death e atte d for	icia	in the past 12 months?	4 ☐ Pregnant at	2 Fetal death time of death	3 □Ectopic p 5 □ Other (s)						Month	Day Ye	ar	
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Records,	w requir been si should I	ted	by no to	1 □Yes							2 - No	2 No 3 Probably 4 Unknown			
ec	Completed Comple							_	24a. Was an autopsy		24b. Were autopsy findings available prior to completion of cause of				
H	The ate	performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Tatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other								death?					
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe			check only one					
o	를 를 들	<u>۲</u>	1 Yes 2 No 27. Manner of Death	To res 20 No 1 Tratient 2 ER/Outpatient 3 DOA											
O	ding h. After	tion	1 Natural 5 Pending		28c. Injury at 2 Work? M 1 \(\text{Yes} \) 2 \(\text{No} \)			28d. Describe how injury occurred							
Division	Attending Physician: r death. sctor: After this certific by the funeral director,	fica	2 Accident investigation 3 Suicide 6 Could not be determined 4 Denside 4 See. Place of Injury, At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number,					ər,	
á	s afte	Certification:	4 Homicide determined	building, etc	c. (Specify)					City or Town,	State)				
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	dical	29a. Certifier Certifying Ph	ysician: To the best of	of my knowledge,	death occurred	at the tim	e, date and pla	ice, and	due to the cau	ise(s) and	manner as	stated.		
	the H nin 24 the F nplete	o o	One)	and manner sta	ated.				curred						
	To To	Σ	29b. Signature and title of certifier	12	Hat	29	c. License	number	(7)	290	d. Date sig	ned (Month	Day, Year)	,	
^			Trucu	1 A 00	1 00	an	L) VI	ta	3	1110	4 03	-2000	>	
2	(b)		30. Name and address of person who	ion flet disuse of de	eath (ftem 23a) (Type, Print	Na	V == 11.	CHI	IAn A	NAIA	PARI	11/12/4/2	/	
2章	Sta	ate	31. Date filed (Month, Day, Year)	A. Registra	ar's Signature	16, 0	111	180 1010	91/6	VOI	70/01	الراء ال	10-19		
	Regist		MAY 0 8 2006		K 4	الأحاد									

06-03119 Please Type or Print in Black Indelible Ink Odysess Anderson State of Maryland / Department of Health and Mental Hygiene Registrar Amend#10b Per FH RC 5-16-06cr Certificate of Death

1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Time of Death Medical Examiner 1645 hrs May 8, 2006 JOSEPH ANDERSON ODYSESS 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Foreian Director 05-20-1979 26 Country) 217-06-6026 1 X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 'n Maryland Prince George's 1 X Yes 2 No 28a-f show Seat Pleasant death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 20743 USA 6610 Clinglog Street or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? 1XX Never Married 2 Married White etc. Yes mit Pages I and 2 should be filed within 72 hours after or partment of Health and Mental Hygone, to protrait: If item 27 is marked other than "natural", o ury or other traumafic event, the Medical Examinate un Yes, Give Year 1 Yes 2 No specify **Black** Widowed Divorced Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than "numatic event, the Medical E Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private +05 Cable Technician 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ulysess P. Anderson Theresa Taylor Be 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ۵ 6610 Clinglog St. Seat Pleasant, Md. 20743 Theresa Anderson 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition 1 XX Burial 2 Cremation 3 crematory or other place) Removal from State Lincoln Cemetery 5-15-06 Brentwood.Md. 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20746 Mary Hidgman Mol374 | Cedar Hill FH Inc. 4111 remi., Ave.

23a. Part I. Enter the difease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cedar Hill FH Inc. 4111 Penn., Ave. Suitland, Md. Approximate Interval Physician Between Onset and /Medical Death Complications of leg injury Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Medical item#23a,27,28a-f,perME,g857,7/15/06 TT X UNPENDED AMENDED requires that the death certificate be Division of Vital Records, P.O. Box 68760, attending phys for use as the bu IF FFMALE 23c. If yes, outcome of pregnancy 23d Date of deliver 23b. Was decedent pregnant in the Physician/ Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown hed for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of death? page 2 : performed? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 / Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 27 Manner of Death Certification: 1 Natural Yes 2 No 5 Pending Director: d in by the f 5/4/2006 7:47 am notorcyclist struck by auto 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State Martin Luther King & Jen Arden Pkwy, Landover, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide within 24 hours aft To the Funeral Di completely filled in determined (Specify) Road Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ical (Check only Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b/Signa ure and title of 29d Date signed (Month, Day, Year) OCME May 11, 2006 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registra

		1 - State Amend Item Registra MEND#IpenMD5/8 1. Decedent's Name (First, Middle, Las		MAE		invale	0, 00	74111	2. Date of De	ath	 	3. Time of Death	
hysici		O HA AAA	ROTHA	MAE	ALI				Month	Day	2006	014-	
Medio/ Examir		4a. Facility Name (If not institution, give	street and number	er)	7. 4.	4b. City, To	wn, or Lo	cation of Death	Total	4c. C	ounty of Death		
-Auttili		Shady Grove						ville			ntgome		
uneral		5. Social Security Number 6. S	9x 7. /	Age (In yrs. las	t birthday)	If Under 1	Year If	Under 24 Hrs.	8. Date of Birt	h		place (State or Forei	
rector		267-08-0569	□M 2 3 F	53	Yrs.	Months D	Days H	Hours Min.	Mar 5	, 195		_{Intry)} Florida	
>		Usual Residence of Decedent 10a, State 10b, County		10.00									
Depertment of Heelth and Mental Hygiene. Important: if Itam 27 is marked other than *natural; or itams 23s or 28s-f show any injury-or other traumatic event, the Medical Examinations to notified at one.	_	Total of Local of										10d. Inside City Lim	
	ecto	Md Montgor	nery		Gai	· -		:g				1 ∑ Yes 2 ☐ I	
	ā	10e. Street and Number 10f. Zip Code 10g.							10g. Citize	n of What Cou	intry?		
M 23	era	2 20070								S.A.			
	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Force	s?	13. W	Yes, specify	Cuban, N	inic Origin? (Sp Mexican, Puerto	ecity Yes or No- Rican, etc.)	- 14	. Race - Amer Black, White		
	by	3 Widowed 4 Divorced	1 ☐ Yes 2. If Yes, Give Year or Dates	5:	1	☐ Yes 2☐	NNO S	Specify:		S	pecify: Bla	ck	
픪	per	15. Decedent's Education 16a. Decedent's Usual Occupation								16b. Kind of Business/Industry			
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2	Completed	12th Grade	College (1-40	3+)	Leg	gel (Cler	k			cks.		
, u	Be C	17. Father's Name (First, Middle, Last)					18	Mother's Name	e (First, Middle,	Maiden Su	ımame)		
i c	ToE	Freddie Ryl	.es					Havar		Dened	ral		
E E		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing	g Address (S	treet and	Number or Run	al Route Numbe	r, City or T	own, State, Zi	p Code) 0.70	
27 i	l J	Michael L. A	li (Hus	band)	793 Ç	Quince	e Or	chard	Blvd,	Gait	hersb	20878 urg, Mi	
a de		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of	of		Date		tion - City or T		
# 2		Donation 5 ☐ Other (Specify) Donation 5 ☐ Other (Specify)						em.5/9	06	Silv	er Sp	ring, Mo	
any inc	1	21. Signature of Funeral Service Licen	1	1					L Home				
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		23a. Part 1. Enter the disease, or comp shock, or heart ailure. List only	lications that caus	ed the death. [Do not enter	r the mode of	f dying, s	uch as cardiac	or respiratory ar	rest,	AVIII	Approximate Interval Between	
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the burial-transit	dlcal		d										
signed by the attending d be detached for use as	/Me	IF FEMALE:	OZa If was autoom	o of									
	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (coasity)							230	 Date of deliving Month 	ery Day Year	
	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
										d tobacco use contribute to the cause of death?			
	d by	Pulmopary Sarcoid								/			
should	etec	To thin the ing see it extends						65 201					
C/I	Completed								24a. Was a autop:	sy	prior to co	psy findings availab impletion of cause of	
page	S	processor and a second							perfor 1 ☐ Yes	2 Z No	death? 1 ☐ Yes	2 🗆 No	
ufter death. Director: After this certificete in by the funeral director, pa	Be	GARIBIES: ,					Place of Death	Check only or	ne)				
	은							Home 5 ☐ Residence 6 ☐ Other (Specify)					
	o	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	(Month, Day Year) Injury Work?					28d. Describe h	how injury occurred				
	cat	2 Accident investigation 3 Suicide 6 Could not be											
	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28l. Location (Street and Number or Rural Route Number, City or Town, State)						
De III		29a. Certifier 1 Cartifying Phy	relations To the book	A = 4 = 1 = 1 =									
completely filled in	Medical	29a. Certifier 1 Cartifying Phy (Check only one) 2 Medical Exam	inar: On the basis	of examination	and/or inve	occurred at the estigation, in r	ne time, d my opinio	ate and place, a n, death occurr	and due to the c ed at the time, d	ause(s) and ate and pla	d manner as s ace, and due to	tated. the cause(s)	
complet	Mec	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated. 29b. Signature and title of certitier 29c. License number							9d Date s	igned (Month	Day Year)		
ö		1/1/1 -				29c. License number P63088				29d. Date signed (Month, Day, Year)			
		WI Yastog				16	308	5	/	Tau	ay 5 m 2006		
											-		
		30. Name and address of person who c	4000	death (Item 23		•		Pogl	cville	MDO	2050		

			State of Maryland / State Registrer	Department of Health and M Certificate of Death		ene g. No. 2006	16000						
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death						
1	/Medic	al	George Bowen Burress		May	3 2006							
	Examin	er	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital	4b. City, Town, or Location of Death Rockville oirthday) If Under 1 Year If Under 24 Hrs.		4c. County of Death	mery						
	Funeral Director		5. Social Security Number 223-30-0684 05. Sex 1 □ ★ M 2 □ F	Yrs. Months Days Hours Min.	8. Date of Birth Dec. 31,1	9. Birth Coi V i	place (State or Foreign intry) rginia						
	fand ow			wn or Location			10d. Inside City Limits						
	Mary a-f eh	tor	Maryland Montgomery	Gaithersburg			1 X Yes 2 No						
	th the)ire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?						
	eth w	ral	419 W. Diamond Ave. Apt. T-3			U.S.A							
980	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show eny injury or other traumatic event, I'm Medical Examinar must be notified at once.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:							
Baltimore, Maryland 21215-0036	vithin 72 houne. Nen "neture Medicel i	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working) life. DO NOT use retired)	ng	e e							
2	Hygia Hygia ther ti nt, un	Co	17. Father's Name (First, Middle, Last)	landscaper		contractin	9						
yland	ould be f Mental I mrked of	To Be	Harvey Burress Ina Belle Dillow										
Man	and 2 sh valth and 27 ie m er traum			Pb. Mailing Address (Street and Number or Rura P.O. Box 985 Augus	ta, WV 2		p Code)						
more	Pages 1. ent of He nt: If Iten ry or oth		1 Burial 2 □ Cremation 3 □ Removal from State	of Disposition (Name of ery, crematory or other place) aven Mem. Gardens 5/8/		rederick,							
Balti	permit. I Departm Importa eny inju		21. Signature of Fig. ral Service Licensee	22. Name and Address of Facility Har	tzler Fu	neral Home							
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Cars Ca										
ı	Examiner	-			/								
	and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
8760,	icate be executed physicien and s the burial-transit	icai E	Due to (or as a consequence d.										
ဖ	ing ph	Med	IF FEMALE:										
.O. Box	The law requires that the death certificate be executed as the been signed by the attending physicien and bage 2 should be detached for use as the burral-transit	Be Completed by Physician/Medical	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	as decedent pregnant the past 12 months? Yes 2 No No No No No No No No									
<u>α</u>	res that signed by be deta		Part ii. Other significant conditions continuoung to death out not resulting in the underlying cause given in Part i.										
Ö	w requir been si should		rambanic water who are significant	100 50	120								
l Rec	Physician: The law this certificete hes la al director, page 2 s				24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of						
/ita	certificate rector, pag		25. Was case referred to medical examiner?	26. Place of Death	(Check only one)								
of o	Physic this c	ပ္	1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐ EP/O 27. Manner of Death 28a. Date of Injury 28b.		ne 5 Residen	ce 6 Other (Speci	(y)						
on	ding h. After fune	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Time of Injury at Work? M 1 Yes 2 No	od. Describe now	injury occurred	1						
Division of Vital Records,	l or Attending Physicien: after death. Director: Atter this certifica in by the funeral director. i	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Co	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place, a nd/or investigation, in my opinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as s a and place, and due t	stated. o the cause(s)						
	o the	Mec	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	Day, Year)						
	MJL		> til hour	D. 20118	(May 3 2	2006						
	4		30. Name and address of person who completed cause of death (Item 23a)	O(Type, Print) Ave Ganhers	burs m	15 208	19						
	Sta Registr		31. Date filed (Month, Day, Year) MAY 0 8 2006 32. Redistrar's Signature	book									